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Community Mental Health Team's Constructions of Service Users with a Diagnosis of Borderline Personality Disorder: An Ethnographic Study

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1. Abstract

The psychiatric diagnosis of Borderline Personality Disorder (BPD) leads to service users experiencing stigmatising and disempowering attitudes from professional mental health staff. To date, a nursing theory has not been developed to understand mental health nurses' personal and professional constructions towards service users with this diagnosis. The development of such theory may enable improved service user engagement, collaboration and recovery for this group of individuals. This study answered the questions of determining the nature of mental health nurses' beliefs towards service users with a diagnosis of BPD and how these beliefs affect their therapeutic relationships with this service user group. An ethnographic approach was used in this study. Data was collected using a combination of observation of the patient assessment and allocation meeting within a community mental health team; and ethnographic interviews with named nurses for service users with a diagnosis of Borderline Personality Disorder. A reflective journal was also kept by the lead researcher. N-Vivo Version 7 was used to aid data analysis and this involved examining the scripts for repetitive patterns or sequences including descriptions, figures of speech, metaphors etc. in order to illuminate differences between different practices and contexts. Findings from the study elicited a model of how CPNs construct BPD categorisations and a potential pathway to alienation is described together with recommendations for the development of CMHTs and CPNs when working with BPD. Development of reflexive practice can be a vehicle for developing alternative **constructions of BPD** and recovery informed practice can reduce stigmatising practices experienced by service users with BPD.

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Contents

1. ABSTRACT	2
ACKNOWLEDGEMENTS	3
CONTENTS	4
ABBREVIATIONS.....	7
2. INTRODUCTION.....	8
3. CONCEPTUAL FRAMEWORK AND THEORETICAL UNDERPINNINGS.....	16
4. LITERATURE REVIEW	22
CATEGORISING MENTAL DISORDER	22
DIAGNOSTIC FRAMEWORKS.....	28
BPD AS CONTESTED KNOWLEDGE	30
STIGMA	33
IN SUMMARY	40
5. RESEARCH AIMS AND QUESTIONS	42
5.1 RESEARCH AIMS.....	42
5.2 RESEARCH QUESTIONS	42
6. METHODS.....	44
6.1 DESIGN	44
6.2 PARTICIPANTS	46
6.2.1 PHASE ONE - OBSERVATIONAL COMPONENT:-	46
6.2.2 PHASE TWO - ETHNOGRAPHIC INTERVIEWS.....	47
6.3 DATA COLLECTION	47
6.4 DATA ANALYSIS.....	50
6.5 ETHICAL ISSUES.....	53
7. FINDINGS FROM OBSERVATION PHASE	55
7.1 CONTEXT OF MEETING	56
7.2 PROCESS OF MEETING	57

7.3 DECISION MAKING FACTORS.....	74
7.4 DECISION OUTCOMES.....	86
7.5 REFLECTIONS ON OBSERVATION PHASE.....	88
8. FIRST ROUND OF INTERVIEWS	93
8.1 INTRODUCTION.....	93
8.2 PRE-ENGAGEMENT.....	93
8.3 SERVICE USER PRESENTATION	102
8.4 CPN UNDERSTANDING OF SERVICE USER PRESENTATION.....	110
8.5 ENGAGING BPD.....	124
8.6 EMOTIONAL REACTIONS TO SERVICE USER.....	137
8.7 RECOVERY FOCUS.....	145
8.8 ORGANISATIONAL FACTORS	148
9 SECOND ROUND OF INTERVIEWS	155
9.1 INTRODUCTION.....	155
9.2 ADJUSTING TO DIAGNOSIS OF BPD.....	155
9.3 SERVICE USER PRESENTATION	157
9.4 CPN UNDERSTANDING OF PRESENTATION	159
9.5 CPN'S EMOTIONAL REACTIONS TO ENGAGING WITH BPD	166
<u>10. CONCLUSIONS.....</u>	<u>176</u>
10.1 IMPLICATIONS FOR PRACTITIONERS WORKING WITH BPD.....	176
10.2 IMPLICATIONS FOR THE CMHT.....	196
10.3 IMPLICATIONS FOR DELIVERING RECOVERY FOCUSSED INTERVENTIONS	206
11.POSTSCRIPT	217
12. REFERENCES.....	225
13. APPENDIX 1: PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM.....	253

List of Figures

FIGURE 1 POSSIBLE PATHWAYS TO THE CONSTRUCTION OF ALIENATION 178

FIGURE 2 ALTERNATIVE APPROACH OF CPNS' COPING WITH FRUSTRATION 193

Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychological Society
BPD	Borderline Personality Disorder
CAMHS	Child & Adolescent Mental Health Services
CATT	Crisis Assessment & Treatment Team
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CPA	Care Programme Approach
CFS	Chronic Fatigue Syndrome
DSM	Diagnostic and Statistical Manual for Mental Disorders
DH	Department of Health
FACE	Functional Assessment of Clinical Environments
FACS	Fair Access to Services
GP	General Practitioner
ICD	International Classification of Diseases
NHS	National Health Service
NICE	National Institute for Health & Clinical Excellence
NVivo 7	Computerised Data Analysis Software
PD	Personality Disorder
PTSD	Post Traumatic Stress Disorder

2. Introduction

Personality disorder according to the American Psychiatric Association (APA) (1994:p275) is

“an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment”.

Borderline Personality Disorder (BPD) is further defined as a pattern of instability in interpersonal relationships, self-image, affect and marked impulsivity (APA 1994:p280). These definitions of personality disorder would suggest that the long standing nature of the disorder, together with its impact on relationships may have a negative impact on effective interventions (Woods and Richards 2003). Service user experience of mental health services are characterised by negative staff attitudes; coercion; and being passed from one service to another (Fallon 2003). An example of these negative attitudes is where staff are encouraged to direct their efforts away from those with a diagnosis of personality disorder in favour of helping those service users with a diagnosis of schizophrenia (Tredget 2001).

Attempts to overcome this deficit in health care provision are highlighted within the policy implementation guidance for people with a personality disorder (National Institute for Mental Health in England (NIMHE) 2003), which indicated that most mental health trusts fail to provide a service for service users with a diagnosis of personality disorder¹.

The policy context providing the underpinning principles to support the process of therapeutic engagement can be found within the for Mental Health (1999a) which identifies the following themes in delivering care:-

¹ The NIMHE Policy Implementation Guide relates to all clients with a diagnosis of personality disorder. This is a general term which is applied to the broad category of personality disorder and the implementation guide also provides specific guidance for specific categories of personality disorder such as Borderline Personality Disorder (BPD). The general term of personality disorder has been used when reference to specific policy guidance but BPD is the focus of this study.

- Accessibility;
- Choice;
- Involvement of service users; and carers in planning care;
- Empowerment and support from staff.

Whilst engagement with service users is ostensibly at the heart of modernisation agendas, there are concerns that this is more rhetoric than reality (Taylor 2001) with growing examples of government policy being akin to sound bites to capture the public's attention to gain popularity rather than tackling the complex problems and issues of the National Health Service. Greener (2004) using discourse analysis of health policy since New Labour came to power argues that health policy has undergone three major shifts. Firstly policy was related to continuity and the role of medical and nursing staff as experts who knew the system best. This was followed by a rationalist performance management approach characterised by targets and standards and lastly by consumerism dominated around the concept of patient choice. The author concludes that government health policy can be likened to a garbage can model with a range of problems and solutions are placed but have no real impact on improving services. To counter these criticisms, the National Institute for Clinical Excellence (NICE) was developed to undertake technology assessments of available treatments and to determine which of those treatments are clinically effective and to be made available to the public. However criticisms of this approach state that rather than end the postcode lottery and improve access for patients the approach has been to restrict access to certain treatments for example in the case of specific cancer treatments (Summerhayes and Catchpole 2006) and the treatment Alzheimer's disease on the grounds of cost effectiveness rather than clinical effectiveness (Kenny 2004; Cerejeira and Mukaetova-Ladinska 2007).

Despite these criticisms the thrust of government health policy has focussed upon further system reform in terms of improving overall quality and standards of service provision by way of the range of policy implementation guides across the mental health pathway including Community Mental Health Teams (2002a), CRHT (DH 2006), and adult acute in-patients DH 2002b).

In support of these reforms Appleby (2007) points to the success of new services in keeping people out of hospital as in the case of Crisis Resolution and Home Treatment Team preventing relapse in the case of Assertive Outreach Teams and more evidence based forms of intervention as in Early Intervention in Psychosis as well as service user access to newer antipsychotic medications and the overall reduction in the suicide rate since the implementation of the National Suicide Prevention strategy. Despite the National Director of mental health's eulogising on the merits of government policy during the past 10 years, the main omission from any mention of success is in the CMHT. This may suggest that as the newer teams and services have modernised (and attracted government funding) the CMHT has not embraced these changes as well and has potentially been left behind compared to other services.

Over the past four years the trend in mental health policy has been influenced by patient and public involvement with the move towards putting service users at the centre of health and social care provision by the introduction of personal budgets (Department of Health 2009a) to empower service users to manage their own health and well being. This model of social care is at the heart of whole service transformation to improve recovery and reduce the social consequences of individuals with long term conditions (Department of Health 2006b; Department of Health 2007).

The collaborative therapeutic relationship is pivotal for the collaborative involvement of patients and carers to improve patient acceptability and treatment concordance. The Department of Health Policy Guidance on Personality Disorder (NIMHE 2003) suggests that this does not occur due to the stigmatising beliefs of professionals. It recommends the effective training and guidance to support professionals working with this service user group to prevent burnout and fatigue. Whilst it has been reported that supervision has been helpful to prevent professional fatigue when working with service users with challenging needs (White & Winstanley 2010), there is limited evidence of evaluation of supervision to professionals working with this service user group. It is suggested that this study will identify professionals' beliefs which may interfere with therapeutic engagement with service users with a diagnosis of BPD and provide an opportunity to evaluate the impact of these beliefs upon therapeutic engagement.

The development of community mental health teams (CMHT) were a direct consequence of care in the community (Department of Health 1995) to provide community orientated mental health care for service users formerly cared for in psychiatric hospitals. However, according to Onyett, Standen and Peck (1997) additional pressures were placed on the work of CMHT's by opening up access to the then conservative policy of fund holding GP's. This resulted in additional power by GP's to demand greater access to shorter term treatments for service user with anxiety and depression and placed additional pressures on CMHT's to respond without additional resources. Such demands led to the development of criteria for service users to access the service and these were generally determined with reference to the label of Serious Mental Illness (King 2001). This categorisation was directly linked to the care in the community agenda of caring for people with mental illness discharged

from institutional care and was found to be legitimate criteria for access to services. Exclusion criteria for the CMHT was related to the treatability of service users and those with addictions, and also the label of personality disorder were regarded as untreatable and denied access to a service. Such service users find it difficult to access services due to the effects of professional stigma and labelling of service users with a diagnosis of personality disorder (Raven 2009).

It would therefore appear that there is a significant paradox present in the delivery of services for service users with a diagnosis of personality disorder. Despite the policy rhetoric of accessibility to mental health services, service users' experiences reflect that professional attitudes can lead to disempowerment, dehumanising and controlling interventions that result in increasing distance between professional and service users (Hall 1996; Markham & Trower 2003). This study will therefore seek to determine how one CMHT determines its eligibility criteria with regard to borderline personality disorder and question and clarify the therapeutic engagement process with these service users who may present challenges for mental health professionals in the form of their presentation, and the beliefs of community mental health nurses.

The Chief Nursing Officer's Review of Mental Health Nursing (2006c) has recommended that mental health nurses adopt the recovery model as their values-based approach to caring for service users in all mental health settings. Approaches with service users which increase power and control, and combat stigma and discrimination underpin the recovery based approach (Allot 2005). Respect, valuing and recognising each service user's uniqueness are additional underpinning principles of the "recovery" philosophy. NIMHE have produced a framework of Values for Recovery (NIMHE 2005) which includes 12 underpinning values, and also highlights

the role of inclusion and collaboration with service users and the instillation of hope. The development of the recovery model challenges the traditional medical and diagnostic models and provides a potential opportunity for mental health nurses to construct alternative identities for service users which may have a positive impact on the therapeutic relationship. From this perspective a recovery model can be viewed as a possible antidote to stigmatising beliefs.

Care settings provide mental health nurses with the social context for the delivery of care (Sun et al 2006). The role of psychiatric diagnoses can have an opposite and destructive effect on this recovery orientated approach (Hall 1996). Some diagnoses are more stigmatising and disempowering (Breeze and Repper 1998), with the diagnosis of BPD resulting in less empathic and helping interventions and more negative responses from mental health workers compared to those with a diagnosis of major depressive disorder (Forsyth 2007).

Whilst there is some evidence as to how mental health nurses categorise service users with a BPD diagnosis, to date, a nursing theory has not yet been developed to understand the content of personal and professional beliefs and assumptions that mental health nurses hold towards service users with a diagnosis of BPD and what these constructions mean for mental health nurses when they are working with service users. The development of such theory will enable improved service user engagement and collaboration with this group of individuals and contribute towards their recovery.

Despite the thrust of modernisation approaches to improve service - user experience, the evidence to date is that community mental health teams have failed to embrace these improvements and it is therefore proposed that a significant paradigm shift will need to occur within the culture of mental health nurses who work within

community mental health teams to develop a culture which will facilitate this emerging “recovery values base”. Part of that shift will need to include critical reflection upon professional and social cultures which play a central role in the development of meaning structures of mental health nurses, and which in turn influence professional reactions to such service users.

Whilst the focus of the study will be community mental health nurses who work as part of the community mental health team, the question of whether the results will be applicable to other professionals who work within community mental health teams is worth considering and will now be explored.

The focus of the study is the culture of the community mental health team which is underpinned by the social context of group interactions and behaviours. People behave differently according to the social context in which these interactions occur. Therefore the culture of community mental health teams will vary according to their membership; group processes, leadership, operational policies, cohesiveness and maturity among other factors. Caution will therefore need to be exercised in drawing conclusions from one professional group and applying the findings across other professional groups within the team and also in applying the findings universally to community mental health nurses in other teams and also to other professionals in other teams given the individual nature of the social context of the team under study.

Members of a culture are shaped not only by their social interactions but also their history and traditions. The discourse associated with the role of community mental health nurse charts their journey from the custodial approaches associated with the asylum with their associations with the medical profession and acceptance of the medical model together with their complicit involvement with coercive treatments such as control and restraint and enforcement of the mental health act may set them

apart from other members of the team such as social workers and occupational therapist whose discourse illustrates an empowering approach to working with service users. This difference in professional discourse may therefore result in different constructions of borderline personality disorder and as such may be further reason to urge caution in attempting to apply the findings of this study from one professional group to another. This issue will be further explored in the conclusion chapter of this thesis.

This study will help develop a theory into the content of the complex nature of mental health nurses attitudes, assumptions and beliefs which both facilitate and prevent therapeutic engagement and recovery-orientated approaches with service users who have a diagnosis of BPD. The results of the study will help develop critical reflection on the taken for granted knowledge about BPD to improve recovery with this group of service users. In addition the results will also be of use in developing practice and cultures to sustain practice development when working with this service user group by reflecting on referral pathways into CMHTs; recovery focussed interventions, and understanding personal and professional emotional reactions to BPD.

3. Conceptual Framework and Theoretical Underpinnings

The starting point for the conceptual framework initially related to Weiner's (1980) model of helping behaviour, which states that intentions to help are facilitated by sympathetic emotional responses and helping is withheld in response to angry emotional reactions. These emotional reactions are a product of the individual helper's, attributions, beliefs and expectations toward the individual who requests help. Attributional dimensions of controllability, whereby the individual is able to exert control over the behaviour for example self harm, and stability of presentation, for example when there is a long standing and pervasive pattern of response as in emotional outbursts in BPD which follows a predictable pattern to elicitation, have been found to cause anger whereas the dimensions of uncontrollability and instability have been found to cause empathic reactions (McGuiness and Dagnan 2001). Using similar methodology Markham and Trower (2003) has demonstrated that similar angry reactions occur more often and more intensely with regard to the psychiatric diagnosis of BPD compared to empathic reactions towards service users with diagnosis such as schizophrenia. Therefore the less likely a presentation to change and considered to be within the control of the individual the more likely the health worker is to become angry and frustrated.

These cognitive models and approaches emphasise the relationship between mental processes and subsequent actions, and that these processes are based on perceptions of the participant and serve to ground cognitive processes in reality. In understanding the cognitive model it is first useful to consider it within the context of a cognitive taxonomy (Ingram & Hollon 1986). Sakamoto (2000) in explaining the taxonomy identifies four distinctive cognitive categories: cognitive structure; cognitive proposition; cognitive operation and cognitive products. Structure relates to

the manner in which information is stored in memory in terms of long and short-term memory. Propositions are the content of the information stored within memory and play a central role in the production of knowledge, in that knowledge is generated within the individual in the form of schematic representation and that this is stored in a hierarchical nature where for example, everyday items of cats or dogs are stored within the category of pets and can be further categorised in terms of breeds or types and can be contained within a general category of domestic animals. These knowledge structures are innate and used to make sense of everyday experience. Whilst categorisation is an important process by which we make sense of our natural world, Edwards (1999) argues that the process of categorisation is actually rooted in social action and that individual's actively construct their versions of reality through repeated social interaction with others. Central to this theory is the discursive psychology (Edwards and Potter 1993) approach which is concerned with the situated use of everyday language whereupon meaning can be inferred and interpreted from everyday language and where the process of talk is viewed as a form of social action.

This is related to discursive analysis that begins with an actual event for example a mental health team discussion about a referral where the discussion is elaborated by the team based on their interpretation of the "facts" and their individual histories of treating people with mental health problems. This then leads to a process of categorisation about the service user and these are based upon the interaction of the team and are known as situated categorisations and will result in a decision about offering a service. Decisions are more likely to be grounded in either blame of the individual, for example when the source of the problem is located within the attribution of controllability, ie alcohol abuse, resulting in the service not offered. Or the decision may be based upon the moral work of the team where constructions

are made on the benefits of intervention and / or whether the service user is deserving of the team, for example in the case of the symptoms of schizophrenia. Such judgements can be forms of stereotype and are arrived at by public discussion (Edwards 1999) and based upon the rhetoric of the situated talk of the team and are central to category construction. Edwards (1999) further contends that through this situated talk those categorical implications are discovered enabling articulation of the social construction of meanings. Hollander and Gordon (2006) have identified the three main categories of tools that individuals use in social construction and these relate to building blocks, linking devices and finishing devices. The building blocks use basic processes for social construction and these relate to categorisation and symbolising. Explaining events, storytelling where there is a link to the past in the explanation and forecasting the future are the tools used as linking devices. Framing or interpretation of events, evaluating these events or situations in terms of good, bad or worthiness; and emoting or the use of emotional expression are types of finishing devices used to persuade others on their point of view. Such approaches are useful aids in attempting to understand the social life and the constructed meanings of participants under study.

Thus discursive psychology approaches (Potter *et al* 1993) contend that participants' constructions of reality are based within and are a consequence of social practices. They propose a model that has three interrelated themes of actions, facts and interest. Actions are performed through discourse. Each action contains a stake of interest managed via attributions of descriptive accounts and factual reports. The analysis of language used in discourse can be used to elicit meanings, and determine accountability (or responsibility) for the reported events.

Further support that meanings for events are socially constructed ² and dependent upon the social norms and cultures in which the individual mental health nurse operates, enabling them to categorise those patients that they considered to be either in need of or undeserving of their help (Kelly and May 1982). These meanings have been found to legitimize power in the therapeutic relationships (Breeze and Repper 1998). When that power is challenged by service users with for example a diagnosis of BPD, by its very nature being characterised by enduring patterns of instability in relationships; mental health nurses make social judgements about such service users (Bowers 2003a) for example by referring to them as manipulative. These judgements can alienate service users and reinforce stereotypical views of service users as mistrustful and “difficult” with seemingly positive behaviour such as compliments being seen as further evidence of manipulative behaviour (Bowers 2003b).

As power imbalances occur within the nurse patient relationship it is also acknowledged that such power imbalances also occur within oppressive social systems and that social and organisational practices which involve nurses can be seen as a set of power relationships (Manias and Street 2001). Within CMHTs the consultant psychiatrist is viewed by service users as the most powerful member of the team with the community psychiatric nurse (CPN) is viewed as power broker between the service user and the psychiatrist (Warne & Stark 2004). According to Manias and Street (2001) critical ethnographic approaches enable the researcher to understand the interaction effects within teams by observing their discourse which can be their situated talk, social routines; work routines; narrative accounts, and reports which contain their taken for granted practices and a source of knowledge. Hammersley and

² According to Bury (1986) social categories are arrived at via the subjective interpretation of others. The degree of pathology attributed to a range of symptoms depends upon cultural and social norms.

Atkinson (1983) state that the reflexive nature of social research is to recognise that the researcher is part of the social world being studied and cannot be separated from the research setting. Such reflexive activities of the researcher play an important role in shaping the context of the setting and thus further exploit and aid data analysis. For example the observed reactions of the team to the researcher are an important source of construction and may generate additional theories to explain the group's behaviour.

Current constructions of working with BPD relate to descriptions of service users behaviours such as manipulation which seek to categorise the individual and confirm the diagnosis and stereotype. However there is a significant gap in knowledge with regard to the situated accounts of community mental health nurses who have to work with such categorised service users and the resultant interactional effects upon the identity of the service user and CPN.

In addition there is therefore a further question mark over the nature of the therapeutic relationship when it can be influenced by these constructions and whether the interactions are recovery focussed which may be a route to emancipation for service users or whether pervasive stigmatising constructions permeate therapeutic encounters.

Recovery orientated approaches and models are dialectically positioned to traditional biomedical models of mental disorder and are a potential source of tension and paradox that the CPN may need to navigate. There is insufficient knowledge regarding this process and resolution of such tensions.

Current constructions of mental health workers related to attributions and evaluations of the service users but to date there is insufficient knowledge and theory as to how CPNs construct their own identity both personally and professionally when working with potentially challenging service users.

The emerging model guiding the design of the study relates to the social construction of service users with a diagnosis of BPD by CPN's. These nurses operate as part of a wider community mental health team and it is contended that through the social and discursive practices of the wider team with it's potential power imbalances will further alter the constructions of the CPN's. These will also be shaped by their histories and interactions within the team, their profession and with other service users. Therefore in order to develop a construction of the CPN's reality it is therefore important to first understand through observing the wider culture of which the CPN is part.

4. Literature Review

This chapter will begin by critically exploring the role of diagnostic frameworks by firstly showing how medical diagnosis is a contested form of socially constructed knowledge that can increase the effects of stigma on the individual with a diagnostic label relating to mental illness in general and BPD in particular. I will then provide an account of how medical diagnosis has survived in contemporary mental health practice to become a dominant discourse and thirdly argue that such medical knowledge is socially constructed and can be manifest within the therapeutic relationships with service users. This theoretical backdrop will enable the understanding of the various discourses that are found within professional constructions of service users with a diagnosis of BPD. Such constructions are bound not only within medical discourse associated with psychiatric diagnosis, but also from discourses related to the historical development of mental health nurses and discourse related to the difficult service user. The impact of these various discourses on therapeutic relationships will be further explored

Categorising Mental Disorder

Diagnoses in mental health are derived from one of two classification systems: the Diagnostic and Statistical Manual of Mental Disorders (American Psychological Association 2000) or the International Classification of Mental and Behavioural Disorders (*ICD-10*, World Health Organisation 1992). Both systems are categorical in nature in that they ascribe a category of mental disorder if a range of criteria are fulfilled. This approach to labelling individuals has been criticised by Mellsop & Kumar (2007) on the basis of variation of ascribed diagnosis by clinicians and also on the grounds that the ascribed categories have not led to individualised treatment plans for service users and have thus not led to better understanding of the disorders instead

leading to clinicians to allocate additional labels to service users under the rubric of co-morbidity which they contend is a poorly understood concept.

In criticising the medical model of mental illness and psychiatric diagnosis, Szasz (1972) asserts that mental illness is a myth and that this is based on three main premises. Firstly, in physical illnesses symptoms are directly attributable to a physical lesion which leads to a diagnosis, and that this biological proof is absent in mental illness. Secondly he denounces the practice of psychiatry at a state level because of the use of the mental health act and legislation which disempowers service users from fully participating in the contractual process. In this sense he maintains that psychiatrists are agents of social control who use coercive means such as legislation to enforce medication to treat individuals and thus maintains a power imbalance in the relationship between mental health professionals and service users. Thirdly the lack of a consensual contract where the service user fully participates and is empowered to participate in the process as an equal participant. This contract is underpinned by the fee paid by the individual to the psychiatrist for his or her services and empowers the service user participation. Thus a key aspect of his rejection of psychiatric diagnosis is not that the experience of the individual is not to be validated but that the explanations and locus of blame is open to refutation. In his model the individual is not viewed as having the problem but that society has the problem and thus uses psychiatrist and legislation to manage society's anxiety with the mentally ill.

Clarke (2007) however criticises this antipsychiatry perspective by firstly stating that psychiatry has moved away from the histological preoccupation with disease to a psychopathological approach that dates back to the original work of Kraepelin and Bleuler with the emphasis upon descriptions of behaviours. Secondly he criticises the preoccupation of the contract which puts psychiatric interventions at the

same level of beauty treatments which Clarke finds preposterous in the least. But perhaps his greatest criticism of Szasz's work is that whilst he deconstructs conventional psychiatry he offers nothing in its place believing that fee paying psychiatry provides validation for the same treatments in the state system.

Buchanan Barker and Barker (2009) in support of Szasz's view accuses mental health nursing of following the same path of psychiatry in terms of being party to implementing a range of coercive treatments, for example enforced medication and endorse the Szaszian view that nurses would be unemployable if they refused to undertake these type of treatments, underlining that nurses are indeed agents of social control. Instead they advocate that mental health nurses need to develop a model of intervention which enables the individual to grow and develop without recourse to co-coercive treatments.

In support of this view Roberts (2007) provides a commentary on anti psychiatry discourse as offering a particular model of how individuals should be empowered to live their life with the implications for mental health nursing to move beyond the narrow lens of the medical model, diagnosis and coercion for a broader social constructionist approach to enabling individuals to cope with their mental health problems in the context of their personhood. Thus endorsing a recovery orientated philosophy.

In further highlighting the various critiques of psychiatric diagnosis from historical, anti psychiatry, and Foucaultian perspectives Pilgrim (2007) argues that psychiatric diagnoses has survived due to three epistemological discourses. Firstly the discourse of medical naturalism is associated with the view that the diagnosis of schizophrenia for example is a naturally occurring phenomenon within those suffering from the labelled disorder. It is seen as an independent phenomenon to

professional observers. Secondly the discourse of radical constructivism infers that diagnoses are socially negotiated outcomes that reflect the stake and interest of the observers for example the profession of psychiatry.

Thirdly the discourse of critical realism combines both naturalism and radical constructivism whereby external reality precedes the subject but is defined by the shifting subjective activity. Thus in this position there is acknowledgement of some abnormality and that this may be further defined as a product of the interests of those actors involved in the series of interactions with the phenomena.

In further criticisms of the DSM system of categorising mental illness Szasz (2007) draws the link between the history of psychiatrist from the enlightenment to contemporary practice of the incarceration of the mentally ill against their will as the principal cause of stigma and that such treatments are coercive and sought to protect the wider society from those deemed mentally ill thus reducing their liberty and sense of power. Corrigan (2007) asserts that clinical diagnosis may in fact increase the stigmatising beliefs of the public towards service users who are diagnosed as mentally ill. He relates that the clinical label may serve as a cue for the stereotypical beliefs characterised by symptoms and disabilities that characterise the population categorised by the label ie people with borderline personality disorder would be expected to exhibit self harm, and conversely if people who exhibit self harm must have borderline personality disorder. He states that stigma is further heightened by the processes of groupness whereby the criteria for inclusion of the group distinguished people from the general or normal population resulting in negative evaluations from that population. In addition the concept of stability - that problems remain the same and seldom improve - thus down playing that recovery is possible for the affected groups, further exacerbates the effects of stigma on people diagnosed with a mental

disorder. He concludes that due to these processes the use of the DSM which was actually intended to help professionals better understand the needs of the mentally ill by classification has actually led to the unintended exacerbation of the stigma associated with mental illness which he describes as structural stigma.

Arguing from a socially constructionist perspective Gillman et al (2000) view diagnoses as being socially constructed in language which are very much dependent upon the dominant ideological and theoretical discourses which shape our value judgements when working with service users and maintain power imbalances between professionals and service users.

These discourses are shaped by the interests of various stakeholders ie professionals to legitimise their knowledge, to gain professional acceptance from dominant professional colleagues, for example psychologists whose work is descended from clinical psychiatrists ie as in cognitive behaviour therapy. Therefore these various interests need to be investigated to enable better understanding of why psychiatric diagnosis continues.

In understanding the social construction of illness, Brown (1995) described 4 categories of illness which serve to understand the relationships between the various social actors and their underpinning social meanings. Firstly he describes a category where illness is accepted by the service user and the illness construction is centred on the illness experience and adjustment to that experience. The second category relates to those conditions that are not considered medical but medical definitions are applied, as in the case of drug and alcohol addiction and understood as examples of medical expansion. Here the medical profession makes one determination of normality and seeks to replace or collaborate with another in the form of the criminal justice system. The construction here could be viewed as a form of social control (to

monitor drug addicts) or one of legitimisation, that drug addiction is an illness which may be less stigmatising for the individual whilst improving their self esteem. The third category related to contested definitions of conditions which exist in the absence of concrete medical definitions. These relate to examples of exposure to environmental contamination and a good example of this is in the case of “Gulf war syndrome” which is contested by government officials despite the large number of soldiers (who have served in the gulf) and are affected by a collection of symptoms. More recently the diagnosis of Chronic Fatigue Syndrome (CFS) which has been accepted by the Department of Health (2002b) as a genuine illness occurred as a consequence of lobbying of government by service user groups and medical expertise to have the condition accepted as a legitimate illness. This illustrates the social construction of illness and diagnosis and how medical knowledge can be shaped by public and political discourse. The fourth category relates to potential medical conditions not yet discovered (within individuals) or latent cases, examples include prediction of genes that cause certain illnesses such as cancers or neurological conditions and those at high risk of potentially contracting those illnesses.

Using the above typology of social construction, the diagnosis of BPD can be viewed as in category two, which attempts to provide institutional legitimacy for service users who experience this label at what the author describes as the macro level, for example directing health policy on Personality Disorder (National Institute for Mental Health 2003) which advocated that it was a disorder of inclusion rather than exclusion from services. However this may be in conflict with those staff working at the front line of clinical services and the micro level concerning their day to day interactions with service users and thus is more likely to influence the practice of mental health professionals with service users with BPD than government policy.

When exploring diagnosis and medical models of psychiatric distress several tensions and contradictions appear from literature. These range from whether mental disorder is viewed from individual biological or social political perspectives; power and oppression or emancipation through the birth of consumerism, though Speed (2007) cautions that this latter discourse which champions market forces and service user choice but does not however deliver any meaningful alternatives to medical explanatory systems.

Having explored the various tensions underpinning the medical model of mental disorder and some of the reasons for the continued dominance of the approach. What appears to be clear is that whilst the experience of people with mental disorder or those who have mental health problems are real the explanatory frameworks that are invoked by various stakeholders are open to critical debate and questioning. These explanations guide professional interventions are therefore central to practitioners' actions with service users.

The dominance of the medical model has been challenged as being socially constructed. Attention will now be focussed upon the discourses associated with the understanding of BPD and this will be undertaken through the dominant discourse of psychiatry and contrasted with socially constructed models of BPD.

Diagnostic Frameworks

BPD is present in just under 1% of the general population, it is most common in early adulthood and women are more likely to be diagnosed with BPD than men (NICE 2009). Within mental healthcare settings BPD is the most prevalent category of personality disorder found within these settings. Between 60-70% of people with a diagnosis of BPD who self harm will attempt suicide at some time in their life (Oldham 2006).

BPD according to Paris (2007) is characterised by emotional instability whereby the individual experiences intense emotional arousal which prolongs itself before returning to a calm state; impulsivity where there is a disregard of negative consequences associated with the behaviour for example, anger and self harm; and cognitive symptoms such as hearing voices, delusions and paranoid feelings. It is a disorder that is characterised by extreme reactions from the service user with intense experiences of anger, sadness, emotional attachment and detachment, self harm such as cutting or taking overdoses, alcohol and drug abuse as well as psychotic experiences.

Nosological systems such as the Diagnostic and Statistical Manual for Mental Disorders (American Psychiatric Association (1994) and the International Classification for Diseases (World Health Organisation 1992) have certain criteria by which the disorder is diagnosed. However, Charland (2006) criticises the legitimization of the label and the classification systems by contesting that the group of personality disorders containing borderline personality disorder are actually defined implicitly on moral grounds (within these classification systems) by which behaviours are permissible by the individual's culture and societal norms, for example the intense anger and instability in interpersonal relationships would suggest some moral deficits in concern for others well being. The author further relates that the treatment contained within dialectical behaviour therapy (Linehan 1993) where the therapist and service user engage in a therapeutic alliance is actually morally rather than clinically focussed as it encourages the service user to overcome earlier moral deficits by developing a trusting relationship with the therapist and work together to overcome identified needs. Thus the development of such a relationship is central to service user recovery.

BPD as Contested Knowledge

The term borderline personality disorder has itself struggled for understanding since its inception by Stern (1938) who thought that the disorder had both neurotic and psychotic phenomenon where he only used psychoanalytical approaches when the service user experienced neurotic symptoms. Various attempts (over the past 60 years) at understanding the concept of BPD has been summarised by Zanarini and Frankenburg (2007) who state that there has been six re-conceptualisations during this period of time. These approaches have attempted to understand BPD as a severe form of character pathology (Kernberg 1975) as a distinct form of personality disorder clearly distinguishable from odd or anxious types such as avoidant personality disorder. The tendency for service users to experience psychotic symptoms elaborated the view that it was a form schizophrenia. The next wave of interest was in the symptoms of emotional sadness and lability and was viewed as a form of affective disorder and also on the border between different mood states for example as a form of bipolar disorder (Akiskal 2002) due to the parallels with the extreme swings in mood.

Later theories focussed upon impulse control and dissociative symptoms leading to views that it was part of the impulse spectrum and post traumatic stress disorders respectively. These conceptualisations have coincided with the major focus of psychiatry for example the diagnosis of PTSD is relatively new in the past 20 years and it's processes were used explain to trauma associated with child sexual abuse and resultant dissociative symptoms experienced in adulthood (Herman & van Der Kolk (1987).

The term BPD is a categorical label and is associated with negative labelling of service users (Nehls 1999) leading to stigma and reduced access to services. Such is the contested nature of understanding BPD as the above theories have

demonstrated, led Tyrer (2009) to advocate that the term borderline and the diagnosis of BPD be abolished as it is meaningless to both service user and clinician as it's meaning conveys multiple concepts in its understanding which actually dilutes its key attributes, resulting in much debate and confusion as to our understanding of BPD. He goes on to further refute the validity of the diagnosis on diagnostic criteria where fewer criteria need to be present to warrant a diagnosis of BPD compared to other personality disorders. This is in keeping with earlier commentators view that the presence of certain features ie self harm, have warranted the label of BPD by the psychiatric professionals (Warne and McAndrew 2007). In exploring the development of the term borderline personality disorder, Manning (2000) drawing upon actor network theory proposes that it is the vested interests of various actors who in turn recruit others into their networks that are the key towards successful outcomes and legitimisation of new ideas. In the case of the legitimisation of BPD, Manning (2000) charts the development of the term BPD in academic papers in the late 60's in response to the cultural norms of 1960's society where the emphasis was upon expression of self through interpersonal relationships, the liberalisation of attitudes and permissiveness which resulted in an increase in the number of individual's who were unable to tolerate such relationships and thus coincided with the growth in them accessing private psychotherapy. Manning's model also draws on two key processes employed by leading academic psychiatrists to obtain legitimacy for the disorder: *simplification* whereby the identification of a new category whose features do not fit into existing categories, and this is played out in *juxtaposition* with a theoretical explanation, for example, of childhood sexual abuse together with the refutation of alternative theories for example no evidence of hereditary factors and was concordant

with the clinical features of the group of difficult patients encountered in clinical practice. These processes confer legitimacy for the categorisation of the label of BPD.

However, such scientific discoveries are open to dispute (Brown 1995) within the specialist field of psychiatric diagnosis due to the higher degree of professional interpretation and bias. Brown further contends that the use of diagnosis is a method for professionals to master emotional control and knowledge over patients and also as a way of exerting social control by demarcating the boundaries between normality and abnormality.

One source of bias according to Bjorkland (2006) is in gender biasing whereby the attributes of women are more expected by society to display emotions whereas men are more likely to be aggressive, accounts for the overrepresentation of women with the diagnosis of BPD. She further asserts that such biasing is a product of the cultural history of personality disorder and that diagnoses as extreme displays of (gendered) behavioural styles. Exploring the social construction of BPD, Bjorkland uses the feminist lens of gender and subjectivity to view symptomatology and the term borderline to underline women's struggle over boundaries that relate to the self, the madness that they experience and the limits of psychiatric knowledge to categorise and understand experience which are constructed by psychiatry as expressions of femininity.

Developing this feminist analysis Shaw & Proctor (2005) linking the relationship between the diagnosis of BPD and surviving childhood sexual abuse suggest that professionals who explain women's psychological distress as BPD further pathologizes these experiences which are further explained as responses to oppression in the form of sexual violence and gender power imbalances that they continue to experience in society. The location by psychiatric professionals of such

distress experiences as residing within the individual rather than the effects of the interaction between the powerful and marginalised in society and therefore as being symptomatic of the diagnosis and presence of mental illness results in further pathology

Stigma

The social constructionist approach to understanding mental disorders and diagnosis relates to the earlier seminal work of Goffman (1961) who captured the essence of categorisation through the patient's experience of the hospitalisation process and describes three distinct processes. Firstly the pre patient phase when the need for hospitalisation is determined resulting in legitimisation of symptoms by the family collaborating with the psychiatric authorities and the resulting feeling of betrayal. The next phases of in-patient and ex-patient phases are characterised by the debilitating effects of stigma resulting in a change of identity and in social networks and relationships. A more detailed description of social categorisation and resultant stigma towards people attending a casualty department is provided by Jeffery (1979) where professional staff categorised good patients as ones in which they were able to practice their skills and expertise. Patients categorised as "rubbish" included drunks, "overdoses" and tramps and regarded as examples of "trivia" by the staff. Despite having medical needs, they were negatively labelled by the staff, were regarded as difficult to manage and resulted in punitive approaches by staff in the form of prolonged waiting time to be seen and verbal hostility. These reactions were related to social and moral judgements of the staff towards patients that they considered to be deviant when compared with more deserving patients and illustrate that staff

comments about these patients are good examples of situated talk as a form of social action.

In a revision of the career of the mentally ill, Gove (2004) explores the pre and post patient phases of hospitalisation and urges the inclusion of service user or lay explanations to conceptualise the experience. For example patients are more likely to endorse the lay view that they had a “nervous breakdown” rather than being diagnosed as “mentally ill” and such understandings are related to the identity associated with both constructions. For example to be mentally ill is associated with deviance, abnormality and stigma whereas mental breakdown suggests that recovery is possible and defines the purpose of the hospital stay: to recuperate from the stressors that contributed to the breakdown and to return to normal levels of functioning. The post patient phase describes the effects of hospitalisation and stigma and uncertainty of whether the mental illness will return. This challenges the construction of self in terms of normality, coping and functioning with everyday life and in reclaiming the status of normality or continuing with madness and deviance.

The reviewed literature on BPD would suggest that the diagnosis is far from clear cut and that the constellation of symptoms that comprise the classification are ambiguous, can be based upon clinical and moral reasoning, cut across a range of personality disorders and that theoretical understandings of the disorder have been shaped by psychiatric discourse which has resulted in the validity of the disorder being further contested by the profession of psychiatry. The effects of the label are stigmatising for service users resulting in defensive practice and reduced engagement approaches with the discourse associated with people who experience the label being further categorised as difficult or challenging (Zittel and Westen 1998, Cleary et al 2002, Bland et al 2007); dangerous and destructive (Woolaston and Hixenbaugh

2008); and manipulative (Bowers 2003a) and will be harder to manage than other service users (Newton-Howes et al 2008).

The literature review will now focus upon the categorisation processes of professional staff towards the classification of difficult patients and the often negative impact upon the therapeutic alliance.

Stockwell (1972) revealed two main attitudes of nurses towards unpopular patients. Firstly those patients who were categorised as grumbler or moaners and who often demanded attention and were ignored by nursing staff. This was underpinned by staff meanings that giving them attention would only make them worse. The other attitude related to patients whom the nurses considered did not need to be either in the ward or hospital. There was a question mark into the nurses perceptions of the genuineness of their problems and this resulted in anger and frustration. The nurses behavioural reactions included them ignoring, rejecting or ridiculing the patients. Despite the age of the study some of its findings are relevant to understanding contemporary staff reactions towards certain types of patients. However additional understanding is required of what it means to form therapeutic relationships with such challenging patients.

Service user experiences of living with a diagnosis of personality disorder, suggest that psychiatric staff have given the opinion that the diagnosis infers that service users are responsible for their actions and are untreatable (Ifell 2002). This is further supported by Castillo, Allen and Coxhead (2001) who found that the most often reported view of professionals towards those with a personality disorder were of labelling service users as attention seeking and therefore not worthy of attention from the professionals. This suggests that an evaluative process was being undertaken by the nurses leading to reduced therapeutic work with the patients. Professionals often

ignored or were unable to understand psychological mechanisms underpinning the distress, for example sexual abuse that is common in service users with a diagnosis of personality disorder (Van der Kolk 1996).

. In addition, Warne and McAndrew (2007) suggest that such approaches to attributing distress may actually contribute to further negative labelling and stigma towards this service user group and further contributes to the inadequacies in service provision and marginalisation by a psychiatric hegemony that is more concerned with categorisation than individualised service user centred care. This would therefore imply that mental health professionals engaged in diagnostic models have their therapeutic gaze on symptoms and symptomatology which is stigmatising and reduces therapeutic engagement and recovery by focussing on service user pathology at the expense of avoiding reflecting on their own internal world when working with BPD.

Some support for this view is provided by Krawitz and Batcheler (2006) who undertook a small survey into the focus of treatment of 29 clinicians working within acute mental health in-patient and crisis teams in New Zealand whilst working with service users with a diagnosis of BPD. The results showed that 85% of clinicians focussed upon symptoms related to self harm and increasing risk which resulted in overly defensive practices of observation and prolonged hospital stays both of which they admit to employing interventions which were not in the patients best interests. Such practices were related to anxiety experienced by clinicians regarding negative outcome and the negative consequences that would follow together with a lack of inclusiveness with service users and their families on the treatment goals and evidence based strategies to achieve these goals

The relationship between “good” and “bad” patients and nurses emotional reactions were also studied utilising an ethnographic method by May and Kelly (1982) where patients who made excessive demands of staff and also where there was a question mark into the true validity of their symptoms or problems. This evoked frustration and anger in comparison to those whose problems were considered to be real and did not upset the running of the ward and evoked feelings of empathy and compassion.

In attempting to understand the care experiences of difficult service users and the difficult patient-nurse relationship Breeze and Repper (1998) report on both overt and covert struggles for control occurring between nurses and service users. Whilst a therapeutic relationship with the nurse was highly valued by the patients in the study, the overwhelming view was that the nurses still did not have enough expertise to help them. The authors have attempted to understand these reactions from a Foucaultian perspective to explain the social context of therapeutic relationships, in that both nurses and patients are in a constant struggle for control and power during these encounters, resulting in some categorisations of service users as difficult or manipulative. However the meanings that mental health nurses construe from such difficult service users are not fully explored, for example the meanings associated with having no control over a service user yet having to develop a therapeutic relationship with the service user is not fully articulated.

The role of social judgements were further investigated in a medical ward by Johnson and Webb (1995) to understand the labels that nurses apply to patients. Using an ethnographic approach the authors found that such labels were related to the moral reasoning employed by nurses in terms of scarce resources and apportioning of their expertise and time. This was also related to the social worth that nurses placed upon

patients. The previous studies provide some detail with respect to the positive and negative interpretations but lack detail with regard to the meaning of these evaluations for the nurses themselves. It is further contended that these beliefs are taken for granted and socially bound, and potentially contain sources of information which may influence the maintenance of destructive patterns in the therapeutic relationship.

Such beliefs were found in a naturalistic study into the mental health nurses attempt to develop therapeutic relationships with anorexic adolescents in an in-patient behaviour therapy unit. Ramjan (2004) found that nurses were unable to form effective relationships due to their pre conceived ideas of the patients being manipulative, with staff blaming the patient for their own problems. This was related to power struggles and perceptions of patients being in control of their behaviour, and highlights the role of judgement and belief in the development and maintenance of barriers in therapeutic relationships. It is therefore essential to develop an inquiry into the meaning of such beliefs to enable mental health nurses to further reflect their impact on therapeutic engagement with service users.

According to Gallop (1988) the diagnosis of BPD results in negative expectations form nursing staff towards the service user with staff endorsing stigmatising beliefs that such service users were both “difficult and demanding”. Thus the reactions to the diagnosis of BPD shaped the discourse of mental health nurses who viewed service users as being troublesome resulting in difficulty in forming therapeutic relationships with them. This was supported by Markham (2003) who undertook a quantitative study examining the perceptions of mental health nurses towards three diagnostic labels: BPD, schizophrenia, and depression. Results showed that mental health nurses were less optimistic when working with this service user

group, experienced more negativity when working with this group and were more socially rejecting of the BPD label.

Approaches to overcoming this impasse have focussed on models of building relationships which relate to theories of power (Breeze and Repper 1998) and alternative explanations of the patient's experience. Examples of this latter approach are provided by Bowers (2003b) who has suggested that stereotypical terms such as manipulation can be understood in terms of either a normal behaviour, as an unconscious process and a cognitive distortion. Similarly, Gallop and Reynolds (2004) suggest that difficult service users can be understood in terms of biological, psychodynamic and socio-cultural theories and that the combination of these approaches provide meaning for the mental health nurse to relate with and make an impact upon the service user's experience.

However, Kelly and May (1982) over twenty years ago, cautioned against these simplistic prescriptive approaches and instead called for approaches that explore the meaning of the relationship. They criticize the available research on empirical, methodological and epistemological grounds. Empirical concerns relate to the lack of generalizability for nurses' beliefs towards the various patient categories identified in the literature with much contradictory and inconsistent accounts. Methodological concerns were related to the use of quantitative rating scales to measure nurses' attitudes which in the absence of direct observation had a limited value on the descriptions obtained. Epistemological concerns related to the implied correlation and causation of the phenomena under study, leaving many questions about the nature of nurse patient relationships unanswered. In addition the major criticism related to the reported nature of patient accounts which appeared to be based upon the presentation of the patients and the observer's beliefs were unreported, the significance being that

the assumptions and beliefs of those observers of the patients are the fundamental components of what determines whether patients are indeed “good” or “bad”.

Speedy (1999) insists that the therapeutic relationship without a therapeutic alliance places the mental health nurse in the role of custodian, as the therapeutic alliance conveys meaning for the nurse and provides understanding into the service user’s current functioning making their behaviour seem reasonable. This would suggest that such meaning may determine the quality of therapeutic engagement. It is contended from the literature that such meanings are derived from unhelpful and judgemental attitudes which do not promote therapeutic engagement and recovery. This study will build on this literature by exploring the beliefs of mental health nurses towards perceived difficult service users in the form of those who have a diagnosis of BPD.

Other attempts to provide alternative meanings for complex behaviours portrayed by service users with a diagnosis of BPD have considered the relationship between symptoms and childhood sexual abuse and psychoanalytical models to explain dysfunctional behaviour (Horsfall 1999). Bowers (2000) suggests the use of staff support and clinical supervision to help nursing staff address strongly expressed feelings when working with this service user group.

In Summary

Whilst the reviewed literature is influenced towards hospital based mental health nurses, it has been included within this literature review as Burr (2003) contends that our understanding of the world, the categories that we use are both socially and historically bound. Community mental health teams were developed as a direct consequence of care in the community legislation (Department of Health 1981) and community mental health nurses were experienced ward based nurses. The

historical basis therefore of community mental health nurses is the discourse of in-patient psychiatry and to fully understand the social reality of this staff group it is therefore important to inquire into how this group of staff construct BPD.

The reviewed literature would suggest that mental health nurses working with service users with stable enduring patterns of presentation and who are likely to have diagnoses such as borderline personality disorder need to be able to develop conceptual models to facilitate better understanding of service user needs and distress. They also need to acknowledge their own emotional reactions to service users during their interactions and attempts to provide care in the face of strong service user reactions. Mental health nurses therefore need to be able to become more aware of their own internal world in terms of their emotional reactions and constructions and categorisations of service users by reflecting on their own beliefs, values, situated language and actions towards such service users and the impact of this upon therapeutic engagement and recovery orientated approaches with this group.

5. Research Aims and Questions

5.1 Research Aims

This study will explore mental health nurses' actions, attitudes and beliefs about developing collaborative relationships with service users who have a diagnosis of BPD. The aims of the research project are to:-

- Describe the beliefs of mental health nurses towards services users who have a diagnosis of BPD;
- Explicate taken-for-granted knowledge of mental health nurses towards services users who have a diagnosis of BPD; and
- To alter practice by provoking critical reflection upon the findings with mental health nurses and practice supervisors by sharing findings with the wider CMHT and nursing profession..

Desired outcomes associated with the research may relate to mental health nurses being more able to:-

- Reflect on their taken-for-granted knowledge of service users with a diagnosis of BPD.
- Explore socially constructed knowledge of CPN's towards the diagnosis of BPD.
- Improved therapeutic outcomes for service users with a diagnosis of BPD by the development of reflexive practice.

5.2 Research Questions

General Research Questions relate to the following:-

- What is the nature of mental health nurses' beliefs towards service users with a diagnosis of BPD?

- How do mental health nurses' beliefs towards service users with a diagnosis of BPD affect their therapeutic relationships with this service user group?

6. Methods

6.1 Design

An ethnographic approach was utilised for this study. According to Laugharne (1995), ethnography is concerned with the study of people in their natural environment. It's focus of study is the cultural group (Morse 1994) where it is assumed that culture is learned and shared amongst members of that group (Hopkins 2002). Ethnography (Hamersley and Atkinson 1983) is the understanding of the culture of those we are studying. As such it cannot be undertaken by standard scientific methods such as neither questionnaires, nor can what is observed be quantifiable or reduced to single entities. In addition the study of cultures cannot be said to represent all similar cultures, that is, what is constructed in one culture cannot be said to be reproducible within a similar culture or be generaliseable to another culture due to the various norms, interactions and characters which shape such cultures. Use of such methodology will explicate the natural language of the community mental health team and CPNs. The use of such an approach can be viewed as a construction of reality of the participants and is a particular analytic stance that is the product between the participant and the researcher (Potter & Wetherell 1995).³

³ The form of discourse analysis suggested by Potter and Wetherell (1987) appealed as framework for data analysis on the basis that it provided a framework for analysing the everyday intelligibility of social interactions. Within this approach, the 'ordinary' social actions of CPN's within the 'normal circumstances' of their practice environments are accepted as already intelligible to others within the same environment, and instead of focussing on 'meanings', analysis concentrates on the effects of utterances / points of view / speech actions etc. and their relevance to others in the same environment (especially those with a diagnosis of BPD). This focus is particularly relevant if, as in the current study, an account of how identities are constructed in day-to-day interaction is required. This orientation has sometimes been described as belonging to a broader set of theoretical and methodological concerns – namely ethnomethodology. As noted above, the broad methodological framework used in this study was ethnographic in terms of the observations made during multi-disciplinary meetings and interviews conducted in the field. The author wishes to emphasise that no special affinity between ethnography and ethnomethodology is being claimed here beyond their broad interpretive agendas (and in spite of the linguistic similarity of the terms). To reiterate, the Potter & Wetherell framework

The main features of ethnography according to Holloway and Todres (2006) are the immersion in a setting and a focus on culture. Use of the approach enables the researcher to capture the emic or insiders perspective from the participants under study resulting in a “thick” analytic description of the culture under study. This thick description makes explicit the patterns of social relationships and the contexts in which they arise.

Fielding (2008) states that ethnography involves the use of combining methods such as observation and interviewing, and the goal of the ethnographer is to understand the symbolic meaning that individuals’ apply to the world in which they live, in this case the work setting of the CPN. In order to achieve this, the researcher needs to adopt the perspective of the members to see they world as they do. The ethnographer uses overt observation and extensive field notes to understand the social reality of the participants within the study. This enables the researcher to use ethnographic interviews to ask questions about the meanings of language, behaviour and events (Holloway and Todres 2006). Interviews are usually in depth conversations to enable the participants and interviewer to fully explore issues within the culture that they consider to be important.

Hammersley (1992) states that descriptions cannot be theories in themselves but descriptions are theoretical in that they relate to concepts and theories and that these are shaped by the assumptions of what is relevant. Ethnographic descriptions present phenomena in new and revealing ways, and ad to our general store of sensitising concepts and models. In this sense they find the general in the particular,

simply provided an appealing set of instructions for data analysis given the aims and intentions of the study.

and the explication and coherence of derived models resulting from the rigour of data collection and analysis provide the distinctiveness associated with the approach.

Ethnographic approaches enable the meanings that give rise to these social processes to be understood (Hammersley & Atkinson, 1983). The primary goal of the method is to describe the culture as a naturally occurring phenomenon, which is external and independent of the researcher (Hammersley & Atkinson, 1983). Potter *et al.* (1993) further propose that representations are constructed within (and are constitutive of) social practices and that subsequent actions and activities are part of interactional sequences involving other people. Emergent attitudes and meanings can therefore be evaluated through observing the enduring practices involving people within a particular interactional setting. The ethnographic approach was used to capture and describe the beliefs and actions of CPNs in their therapeutic setting with service users with a diagnosis of BPD.

6.2 Participants

Access to potential participants was obtained from a variety of sources. Authority to conduct the study within the study setting of Community Mental Health Teams (CMHT) was obtained by writing to the Director of Adult Mental Health Services. CMHT team leaders were approached by the researcher to explain the research study, provide participant information sheets and consent forms, and enable potential participants to opt into the study. The location for the study was in CMHT's across the Northumberland Tyne and Wear NHS Trust. The study was undertaken in a mental health trust. A theoretical or purposeful sampling strategy (Polit *et al* 2001) was adopted. The participants met the following criteria:

6.2.1 Phase One - Observational component:-

- Professionals involved in clinical discussions about service users;

- Works in community mental health team setting;
- Consents to participate in the observational component of the study.

6.2.2 Phase Two - Ethnographic Interviews

- A registered mental health nurse;
- Have current experience of being a named nurse for a service user with a diagnosis of borderline personality disorder;
- Agreed to meet with the principal researcher on a regular basis during the data collection phase of the study.

6.3 Data Collection

Data was collected utilising a range of strategies. A theoretical or purposeful sampling strategy (Polit *et al.* 2001) was adopted. Data was collected in two settings. Firstly, the researcher acted as an overt participant observer in multidisciplinary team meetings (Johnson 1995). A purposeful sampling method was used to select participants. According to Patton (1990) purposeful sampling is the selection of a small number of cases that are information rich about the concepts under study and purposefully selected by the researcher. One CMHT within the Northumberland Tyne and Wear NHS Trust was selected to participate in the study. The criteria that underpins team participation is supported by the DH (2006a) Personality Disorder (PD) Capacity Plans which propose six tiers of service provision for service users with PD. CMHT's are located on tier 2 which recommends complex needs assessment, multidisciplinary care and access to intensive community care management. This enabled further articulation of how service users with BPD access this level of service provision; and the factors which influence the gatekeepers of the service to grant this access (McEvoy 2000); and a description of the discourse relating to the team's understanding of BPD which will influence decision making (Wright *et*

al 2007) about whether the service user will be offered a service; and the allocation of the service user to a care co-ordinator. This last component demonstrates to service users with a diagnosis of BPD that they are progressing within the mental health care system and provides an opportunity to relate to a meaningful other (Fallon 2003).

The first phase of the study comprised an observational component of the selected CMHT's assessment and referral meeting. CMHT's are multidisciplinary and are made up of medical, nursing; social work; occupational therapy; psychology and support workers. There are approximately 30 members of clinical staff who work within CMHT's and on average 17-22 of the CMHT staff attend the weekly referral and assessment meetings. Permission was sought (on each occasion) from those staff in attendance to observe the assessment and referral meeting. A total of five observations of the meeting were required to obtain an understanding of the culture in which the participant's social meanings were constructed. This formed the observation part of the study and enabled an etic⁴ perspective to be obtained (Sorrell & Redmond 1995).

Data was collected in two principal forms: field notes were recorded by the researcher during the observational part of the study and reflected upon. This approach enabled the researcher to become an instrument of the research (Hopkins, 2002) as the journal attempts to capture the dynamic between the emic⁵ and etic perspectives. This questioning of the data also provides a constant validity check of the data (Burnard 1994). Secondly individual named nurses for a service user who has a diagnosis of BPD were invited to take part in ethnographic interviews, which

⁴ The etic perspective is related to understanding of the totality of the social group's observable behaviour, routines and daily life (Sorrell & Redmond 1995).

⁵ The emic perspective relates to understanding the perspective of those who are in the inside of the experience., that is those who participate within the experience. It defines the culture in a cognitive manner by describing the ideas, knowledge and beliefs that are characteristic of the group (Sorrell & Redmond 1995).

were recorded on audiotape. The ethnographic approach suggests that all members of the culture or sub culture be selected for study. There were 7 CPNs working within the CMHT and these were approached to participate in the ethnographic interviews. This purposeful approach was justified as the study recruited a small number of individuals who were able to reflect upon the cultural practices enacted within the setting under study, and possessed specific knowledge and experiences that they are able to share with the researcher (Higgingbottom, 2004).

Consent was obtained from all professionals who participated within the CMHT multi-disciplinary team discussions, for the lead researcher to be present at team discussions. A full information leaflet was provided to describe the potential risks and benefits of participation.

Additional consent was obtained for named nurses of individual service users to participate in the ethnographic interviews⁶. From a sample size of 7 participants, 3 CPNs met the study criteria for inclusion and agreed to participate in this longitudinal study. According to Murphy-Black (2000) longitudinal research uses data that is collected over time and can include either quantitative and qualitative data, and the author states that these time differences can be short (a month apart) or long up to 10 years apart.

There are significant challenges for professionals when working with service users with a diagnosis of BPD in terms of their continued engagement with the CPN.

⁶ Pierre Bourdieu (1977) defined habitus as the set of acquired patterns of thought, behaviour, and taste, claimed to constitute the link between social structures and social practice. Similarly, the focus of the current study was to describe the dispositions of CPN's to act in a certain way and their 'reference points' for action / description etc. towards BPD. Bourdieu suggested that habitus is acquired via socialisation and predisposes to a natural way of thinking and acting, which on closer inspection, is in fact the result of socialisation. The author would simply wish to note here the affinity between Bourdieu's claims and the claims made above in relation to professional socialisation of CPN's, and the ways in which this socialisation manifests itself in terms of actions (e.g. MDT meetings) and words (e.g. emergent during the course of interviews).

These may occur due to issues of transference and attachment which may result in disruption in the therapeutic alliance, with service users discontinuing contact with the CPN and CMHT. This study is primarily concerned with how CPNs develop collaborative relationships with service users with BPD therefore those who drop out of contact with the CPN will enable investigation of those processes which may interfere with the development of collaborative relationships and will therefore be an important source of data for the study. These interviews are therefore part of the ethnographic process and can be considered as critical cases (Hammersley 1992).

Each of the participants were allocated a personal identifier by the researcher. Each interview was of approximately 60 minutes duration. The researcher met with each participant on three occasions during the course of the CPNs' engagement with the service user. This was at the beginning, 3, and 6 months into the duration of the engagement process. Ethnographic interviews were tape recorded and were subject to additional informed consent being obtained from participant. These interviews were transcribed by the researcher for data analysis. All data was stored in a secure location, accessible to the lead researcher, and disposed of 1 year after the completion of the study, in accordance with the Data Protection Act (1998).

6.4 Data Analysis

A social constructionist perspective has been used to underpin the precepts of this study: A combination of approaches to qualitative data analysis was utilised. More specifically:

[1] The ethnographic approach used in the data collection phase of this work yielded both (a) observational components, and (b) taped ethnographic interviews. The main researcher maintained field notes of the observations and these were analysed and provided a methodological self consciousness (Lynch 2000) which enabled the

researcher to take on a reflexive role, helping to identify the researchers own assumptions, interests, and active role in the generation of this data. General ('sensitising') concepts emerged from the data and these were used to suggest further directions for ethnographic exploration (Hammersley and Atkinson 1983).

[2] Burr (2003) has suggested that a constructionist approach is characterised by taking a critical stance towards taken-for-granted knowledge arising from mundane social processes such as conversations and discussions. These sources of knowledge are populated by underlying concepts and categories which it is anticipated will vary between care settings. Data was initially analysed utilising the methods outlined by Hammersley and Atkinson (1983) whereby the interviews were read to familiarise oneself with the data and to examine the general patterns contained within the observed sequences of action and interaction. This enabled the researcher to determine the initial 'topography of the texts' (Lofland, 1970). The outcome of this process allowed the researcher to assemble all the materials and form an impressionistic account of how participants deal with the experiences under study i.e. to tease out any variations, classify into types and strategies, and present these findings in an organised manner. Similar concepts were grouped together to form categories containing similar properties. The categories were subject to comparative analysis with other existing and emergent concepts (Koch *et al* 2006). Nvivo[®] Version 7 relational database software was used in order to facilitate this process. However, in undertaking this aspect of analysis, the researcher was conscious of the dangers of losing the holistic qualities of the data, and [3] below, served to counter any reductionist tendencies.

[3] Ethnographic investigation presupposes that knowledge, interaction and social actions are inseparably linked together and become bound in situated social norms that serve to frame what is permissible in terms of actions towards and treatment of other people within the same social setting. According to Potter & Wetherell (1987) the operation of taken-for-granted knowledge can be revealed by focussing upon (a) dilemmas of stake and interest in interaction, and (b) the methods and means by which blame and accountability are constructed and managed in social actions (including retrospective accounts of these actions). Although Potter and Wetherell's methodological prescriptions were originally made in respect to their distinctive style of discourse analysis⁷, the approach has much to recommend itself in terms of this study as it is concerned with both observable actions as well as actions contained within the accounts that were obtained from the interviews. In the observation phase of the study it has already been found that these actions are of accepting or rejecting service users referred to the Community Mental Health Team. Related to these actions are the 'factual' accounts of the events of the assessment: Dilemmas of stake or interest both within the team and between the team and the referred service user are already apparent and serve to frame the actions and outcomes of the meeting. This data analysis approach was maintained for the remainder of the study i.e. examining the scripts for repetitive patterns or sequences including descriptions, figures of speech, metaphors etc. in order to illuminate differences between different practices and contexts.

In summary, this data analysis process led to the discovery of the underlying social processes framing interactions in this particular field setting, and allowed for

⁷ Discourse analysis is the "theory of and methods of studying social practices and the actions that constitute them" (Potter, Edwards & Wetherell 1993: 383).

the generation of mini-theories which in turn led to the production of an explanatory framework, model, and theory.

6.5 Ethical issues

Ethical considerations relate to anonymity; confidentiality; truth telling; management of sensitive information; whistle blowing; and prevention of harm.

Ethical issues relate to the participants (mental health staff) being able to opt in to the study voluntarily without the potential for being influenced to participate, particularly since the lead researcher may have been known to some of the potential participants. This in addition may influence recruitment and participation in the study. However the study settings of community mental health teams across the trust makes this less likely to affect recruitment. This was monitored by the lead researcher with repeat distribution of invitations in the event of low recruitment.

It is important that the principle of justice and fairness was applied and that all potential participants were able to join the study, without receiving preferential inducements to participate. The use of an opt-in consent form helped to overcome this. In addition there was the potential for concerns about the content of the information that the CPNs' may have disclosed and who would have access to it. This related to issues of confidentiality and right to anonymity. To overcome this, the lead researcher ensured that the governance procedures relating to the study adhered to the above principles and those individual participants were not identified. This was clearly written in the information leaflet.

Other potential concerns from participants were that any potential negative information was not relayed to their line manager for fear of disciplinary recriminations. This was also reflected in the information leaflet. This may have affected the quality of information that was disclosed by participants. Conversely

ethical considerations for the researcher were that malpractice could have been disclosed by the participants(s) or a particular range of attitudes are uncovered which lead to anti-therapeutic interventions which would lead the researcher to become whistleblower on the participants. It was made explicit to participants that in circumstances in which the professional code of conduct has been breached that further action will be taken. This was identified in the information leaflet.

The use of repeated interviews may be time consuming for the participant. During the process of participating in the interviews, participants may have become upset when reflecting on their experiences with specific service users. Information relating to this risk was highlighted within the information leaflet and additional support would be provided to the participant by the lead researcher and also by the use of supportive measures in place within the trust ie the use of clinical supervision structures and other pastoral care approaches.

7. Findings from Observation Phase

Four main categories emerged from the observation component of the study and these are shown in table 1 below. These will now be explored in more detail.

KEY PHASES IN DECISION MAKING PROCESS	ELEMENTS
7.1 CONTEXT OF MEETING	<ul style="list-style-type: none">• PHYSICAL ENVIRONMENT OF MEETING ROOM• PHYSICAL ENVIRONMENT OF OFFICE ACCOMODATION
7.2 PROCESS OF MEETING	<ul style="list-style-type: none">• GETTING STARTED• INTERACTIONS• TEAMWORK & CONFLICT• POWER
7.3 DECISION MAKING FACTORS	<ul style="list-style-type: none">• STEPPED CARE: PREVIOUS HISTORY OF INTERVENTIONS• PRESENCE OR ABSENCE OF RISK• CONTROL OF WORKLOAD DEMANDS• COINCIDENCE OF PRESENTATION WITH TEAM'S "FAMILIAR CATEGORIES"• POSSIBILITY OF OTHER MENTAL HEALTH PROVIDER INPUT
7.4 DECISION OUTCOMES	<ul style="list-style-type: none">• SERVICE OFFERED• SERVICE DECLINED

Table 1: key factors from observation phase of study

7.1 CONTEXT OF MEETING

Physical Environment of Meeting Room

The CMHT is based within a brand new NHS walk in centre which contains primary care staff such as GP's, district nurses etc. These are located on the ground floor level. The first floor is for the Chronic Fatigue Syndrome Service and the third floor is where the CMHT is located. The centre is based within the community and is set a street back from the main shopping centre in this part of the city.

The meeting room is where the weekly business of the CMHT takes place. Decisions are made in this room about service users referred into the CMHT. The meeting room brings together the CMHT members and I have termed this an event as there is a sense of occasion about the room, about it's once weekly use to facilitate the team to work together, to make decisions and to socially bond with each other.

“The meeting occurs in a venue within the centre which is away from the normal bustle of the department. The mental health team have to physically move from their offices and shared space to arrive in time for the start of the meeting and remain there for the duration of the meeting. It is the main occasion for the entire team members to be together throughout the week.”

The meeting room is across the landing from the main reception and offices of the CMHT workers on the 3rd floor. The room consists of a series of tables arranged in the centre of the room in a boardroom style. It resembles a rectangular shape. Along the long side at the back of the table there are 4 chairs and three along the front. To the short sides there are two chairs on each side. There are stacks of chairs around the room in piles of three waiting to be dismantled to take their place around the table.

The table takes centre stage like an arena awaiting its competitors, the table awaits its companions who will shortly arrive to take part in the meeting. The room is modern, functional, fresh and businesslike, free from clutter but impersonal. The

atmosphere is calm, quiet and sedate and I sit in the back row just off the table beside the stacks as I await the others to arrive.

The CMHT consists of three consultant psychiatrists, usually a junior doctor in training such as a senior house officer, the team manager who is also a CPN, an occupational therapist, four social workers, five other CPNs and two support workers. There can also be students of each of the main professionals represented within team. There is also the team secretary present who co-ordinates the paperwork for the meeting and also records the team decisions that are made.

Physical Environment of Office Accommodation

Behind the façade of the meeting room the team members are allocated office space to enable them to get on with their day to day work. The spaces are of two different types: a row of offices accommodating one person each is on the outside of the corridor. These are allocated to the team manager and the consultant psychiatrists. The second type of space is shared space where the rest of the team members operate from. There appears to be a distinct boundary which separates the team members from the medical staff and team manager and this may have some impact on the sense of occasion that arises when the team meeting occurs on a once weekly basis.

7.2 PROCESS OF MEETING

Getting Started

Humour occurs at the beginning of the meeting as the team members arrive and settle themselves into position waiting for the meeting to formally begin:-

Pete chairs the meeting and introduces me and underlines that I will be here for about 15-20 minutes to talk about the study. He suggests a round of introductions and as we do this the CPN that I met in the lift acknowledges that she met me in the lift. The next CPN states her name and rather flirtatiously stated that she wished she'd also met me in the lift. I reply with some humour about wanting to work in a friendly team which seems to deal with the embarrassment of the situation.

The use of humour in various guises is used by the team as way of building the cohesiveness within the team. This can be in the form of humorous comments made about service users made in the context of the referral meeting:-

“Humour is injected into the meeting at this point with the last new referral who has a Scottish name and there is much play on his name and a reference to the “clan x which rhyme together, much like “Andrew of the clan McAndrew!”

In a study of community mental health teams use of humour, Griffiths (2002) using an ethnographic approach found that humour usage can be helpful in team building where humorous comments by one team member are endorsed and shared by the group.

The team use a pre printed proforma which guides the process of the CMHT referral meeting. The proforma comprises 5 sections with some allocated times. Firstly the meeting reviews new service users who have been referred (no time allocated); update on inpatients (15 minutes); new assessment feedback (no time); waiting list update (10 minutes total); case reviews (5 minutes each patient). During the discussion on one of the new referrals a consultant psychiatrist remarks that the “doctors see most of the patients” referred to the team and this raises questions about how cases are allocated and more importantly what does the constituent members of the team have to offer and provide for the service users. This remark can be better understood in terms of the medical staff’s clear and exclusive remit within the team in terms of diagnosis and prescribing of medication. From this perspective decision making and allocation is often dependant upon the team’s need for service user diagnosis and medication, underlining the dominance of medical discourse. The power and dominance of the medical profession within the team is demonstrated

within the design of the proforma in that the address of the GP is inserted beside the service users' name which highlights which doctor covers that practice. This infers that the medical staff has primacy over the referrals and therefore may account for why they "see most of the referrals".

Inter professional working within CMHT's can be enhanced according to Lowe and O'Hara (2000) by the development of a clear operational policies, team meetings; same office space; clarity around roles and responsibilities, common policies and teambuilding activity. However according to Larkin & Callaghan (2005) who utilised quantitative surveys of 165 multidisciplinary workers in an East London mental health trust, found no relation between meetings and their influence on developing inter professional working within CMHT's. This would tend to suggest the need for further investigation into CMHT team meetings in terms of their structures and processes which facilitate participation and effects on inter professional working.

INTERACTIONS

Teamwork & Conflict

According to the Mental Health Policy Implementation Guide (2002a), CMHT's should see two types of patients: firstly those with time limited mental health problems who would be referred back to their General Practitioner's care after approximately 5-6 contacts; and secondly those service users which require more longer term care, treatment and monitoring lasting several years. The latter group would comprise a substantial component of the CMHT's caseload and specifically identifies within this category those service users with "severe disorders of personality" who have not been taken on for a service by a specialist psychotherapy service or in receipt of an assertive outreach team.

The CMHT is made up of medical, nursing, social work, and occupational therapy staff. Each of the professions contribute to the referral and assessment meeting. Power can be demonstrated in the form of language used by various professionals within the team. Medical language relates to the biological or disease model where there is a need for a psychiatric assessment, to discover the psychopathology of the service users presentation (in terms of psychopathology it's early days"), the presentation of symptoms and whether they are genuine ("she may have pseudo hallucinations"); the determination of a diagnosis (it doesn't look like a paranoid schizophrenia, maybe secondary to drug use"); and the complexity of determining this ("it doesn't add up"). The role of the psychiatrist in the team is related to diagnosis, and medication treatment, as the following case illustrates:-

"Kim was presented by the German psychiatrist. She has been taking an atypical antipsychotic for 6 years without her physical health being monitored. A significant side effect of this medication is raised prolactin levels which can cause enlargement of the breast with painful discharge. Kim was presenting with Galactorea and ulceration of her breast and was none the wiser as to the cause. She had been referred by her GP who believed that the cause of the raised prolactin was an abnormality of the pituitary gland rather than the medication. The psychiatrist was apologetic (for his colleague and for the pain the service user had experienced), I don't know how she got to this stage". His main goal was to reduce the prolactin levels and improve her physical health. This was to be achieved by switching to another antipsychotic with a different side effect profile and monitor help responses both physical and mentally. His main role was a prescribing role and he was solely involved in the care of the service user".

An illustration of the social work role is provided by the following service user referred and accepted by a social worker:-

"Ahmed is a failed asylum seeker and is homeless. He has left his accommodation fearing that he will be locked up by police due to his failed asylum status. He has made some contact with a refugee service and is suspicious of authority and agencies for fear of deportation. He is therefore difficult to engage. The social worker presenting the case's discourse is related to protection and surveillance and primary intervention is to reduce homelessness and the service user's vulnerability. His intervention is to apply for Section 21 and obtain funding for accommodation, with the outcome of re-housing the service user.

A CPN's perspective is demonstrated by the following referral:-

“Billie Jo is another failed asylum seeker who is suicidal and also 35 weeks pregnant. She was a victim of rape in Africa and there is some suggestion/ question (from the team) that the baby is a product of the rape. She is unable to return home (to Africa) as women who have been raped are viewed as shameful with the punishment of death. There is considerable empathy within the team to the woman's plight. The social worker states that the perinatal mental health team won't see her, as they do not believe she is “one of their service users” Team discussions centre around the impending birth and the need to provide a safety cushion for the service user following the birth. The social workers are also concerned with the unborn child's welfare and there may be safeguarding issues involved. Medical staff will undertake a mental health assessment together with a risk assessment and management plan. They are unable to prescribe medication due to the pregnancy. The CPN's offer a liaison role by following up with the perinatal team and also the crisis resolution team ensure that “they have a plan in place”

These three cases highlight some of the complexities in providing a service with what Evers (1981) refers to as a specialist team which contains a variety of tasks and variety and levels of skills. Within the CMHT practitioners provide a service depending upon their statutory functions as in the case of social workers, according to expertise ie in the case of medical staff and a supportive role in the case of CPN's. These can also be viewed in terms of the power contained within the team's discourse which appears to be hierarchical in nature with decisions to accept service users being made initially in terms of diagnosis and medication needs (medical); service user vulnerability (social work and nursing); and for the need for ongoing monitoring and support ((social work and nursing); or for support in the administration of medical treatment for example monitoring of medication (nursing).

However the determination of a distinct professional role is far from clear cut. Lankshear's (2003) study into service user allocation in a CMHT's found that a strategy of manipulation was proposed as a term for the game playing that occurred by staff presenting cases to the team with certain words being emphasised to illustrate that the case may need the input of a particular professional, for example the over

emphasis on medication monitoring would lend the team to suggest a CPN allocation. Another strategy was termed homogenisation whereby the team would respond to external pressures as an integrated team putting forward the consistent voice of the team. A final strategy of demarcation was used when team members felt that they did not belong professionally to a team or their professional voice had been taken away. Examples of this were when social workers and occupational therapist who had traditionally worked in professional teams and now felt professionally isolated when integrated within community mental health teams

Using a discursive psychology approach to understanding the process of role blurring and boundaries within professionals working in community mental health teams in the midlands, Brown et al (2000) found that positive aspects of role blurring was professionals' attempts to provide more holistic care for service users, and that this represented practitioners engaging with their role as part of the modernisation agenda. They found that blurring of roles within the team resulted in a move from the dominance of the medical model amongst nurses and psychiatrists to practitioners incorporating more social models which influenced their practice. However blurring was most common amongst occupational therapists, nurses and social workers and this perhaps can be accounted for as the professions with least power compared to medical colleagues (Warne & Stark 2004). Conversely blurring was perceived as dangerous when it was viewed as some professions as "meddling" in the work of other professions and did not serve the best interests of the service users and occurred at the expense of teamwork, involving other professional expertise in the care and this occurred as a consequence of increasing caseloads. In this sense blurring of professional roles can be seen as a method of rationalising resources to meet workload demands of the CMHT.

This blurring of roles together with approaches aimed at the reducing power inequalities within teams such as the flattening of hierarchies within teams were a further method of promoting interdisciplinary working in integrated teams. This move towards more democratic ways of working resulted in professionals being less effective, for example in chairing clinical meetings as they were often under prepared for the role, resulting in worker inadequacy rather than a more empowered workforce. This resulted in professionals' adopting roles and boundaries consistent with their professional roles and is explained by the authors as a method of increasing their sense of security. Thus as the institutional boundaries became less hierarchical with less demarcation there was a tendency for professionals to attenuate the boundaries of their professional practice. Brown & Crawford (2003) refer to this adoption of professional boundaries in the absence of clear managerial control of community mental health teams as "Deep soul management" where professionals can be seen to self regulate their work patterns and cling to professional identities in the face of less directive management approaches and the reorganisation of healthcare and provider roles respectively.

This tendency to articulate difference in expertise between team member roles is consistent with the work of Xyrichis and Ream (2008) who undertook a concept analysis of the term teamwork using Walker and Avant's (2005) method of concept analysis. The authors define teamwork (p238) as:-

"a dynamic process involving two or more health professionals with complimentary backgrounds and skills, sharing common health goals and exercising concerted mental and physical effort in assessing, planning or evaluating patient care. This is accomplished through interdependent collaboration, open communication, and shared decision making. This in turn generates value added patient, organisational and staff outcomes."

Relating this definition to the observation of the CMHT, the first concept relating to two or more professionals involvement in the care of a patient is absent in

the categories of referred service users who have moderate impairment and require the service of one member of the team for a time limited period. This results in a case being made for the service user to be taken on for a service and potentially for a specific worker to be allocated ie nurse, social worker or doctor. This creates tension and potential for conflict which would appear to result in the concepts of interdependent collaboration characterised by the absence of a hierarchy and respect towards fellow team members involved in the care of a service user, being challenged which further erodes the integrity of the teamwork concept. That is colleagues rather than respected are viewed as a method of workload management which do not generate value added outcomes in the areas described by the authors.

Psychiatrists' perceptions of the factors that influence effective teamwork in CMHTs were investigated by Herrman et al (2002) who observed meetings of the Australia and New Zealand College of Psychiatrists professional liaison committee to provide recommendations to the College on training and leadership development for psychiatrists to improve teamwork in CMHT's. They found five main factors that affected the quality of teamwork. These were related to ambiguity and conflict over roles; conflict and confusion over leadership; differing understandings between responsibility and accountability; interprofessional misperceptions and differing rewards between professions. A common theme running through these factors was the psychiatrists' view of their profession as leaders of the team which many of them endorsed due to their length of training, and their contention of medical responsibility being asserted in terms of overall clinical responsibility for the patient and by extension responsibility for the team. Interestingly the authors' conclude that psychiatrists as well as other team members should receive training in team dynamics and process, joint collaborative projects with other team members and the

development of professional leadership roles for psychiatrists rather than administrative roles.

The consultant psychiatrist's role within the community mental health team when viewed by team members such as CPN's, social workers and occupational therapists (OT's) can be that of a resource rather than as a source of direction (Brown and Crawford 2003), which is contrary to the belief of medical dominance within multidisciplinary teams. They are a resource in terms of their expertise in medical diagnosis and medication prescribing. This however, may be challenged in the future by the developments in non medical prescribing.

The role of the CPN has changed since the introduction of the Care Programme Approach (CPA 1999) which was a system introduced by the Department of Health in response to the confidential inquiry into suicide and homicides by service users with a history of mental disorder (Department of Health 2001). CPA was introduced to prevent service users from "slipping through the care net" and consists of a process of assessing the health and social care needs of service users with a clear care plan to address those needs. Monitoring service users' mental health, medication concordance, risk factors, crisis monitoring and contingency management are underpinned by the role of care co-ordinator

Tensions between the role of the care co-ordinator and that of the CPN was explored by Simpson (2005) who found that the medical model dominated the practice of CPN's where one respondent likened his role to that of a "psychiatric police officer", with the effect of them being unable to utilise psychological therapy skills to promote recovery due to the care co-ordination emphasis and increased administrative work that this involved. Lack of clarity of what constituted the care co-ordinator role contributed to uncertainty of the role and performance of the role. The

author concludes that the increased role blurring of the care co-ordination role has resulted in the dilution of the CPN role to what he has labelled “limited nursing” whereby the increase in statutory risk assessment and management approaches has resulted in the elimination of psychotherapeutic work with service users and significantly contributed to the potential relapse and readmission to hospital for service users.

Exploring the factors which enabled CPN’s to effectively carry out the role of care co-ordinator; Simpson (2007) found that the role of consultant psychiatrist was pivotal in whether positive relationships were fostered within teams. Crucial to this was the psychiatrists respect and valuing of colleagues and where there were clear evidence of an undermining approach, team members did not contribute to the team meetings effectively and this had a negative impact on carrying out care co-ordination responsibilities. Power inequities lay at the heart of these interactions and the role of the team leader in this study appears to contribute to structures and procedures surrounding team meetings rather than address these power imbalances that are inherent in the CMHT’s reviewed in the study.

Exploring service user perceptions of the role of different team members within a CMHT, Warne and Stark (2004) found that service users did not feel that they experienced a team approach to care provision and viewed the consultant psychiatrist as the most powerful professional group, as they could arrange admission, and direct other staff within the team. Mental health nurses were viewed as the most helpful members of the team and were perceived to have an intermediary role within the team negotiating services between different professionals on behalf of the service user. Social workers whom the services users had the most contact with were perceived to be the least helpful of the professionals involved in their care.

This dichotomy regarding the tensions and factors influencing collaboration and integration of mental health workers and social services was further investigated by Magnusson & Lutzen (2009) who found that there were two major themes which affected collaboration in caring for people with schizophrenia on a long term basis. These related to external organisational factors associated with policies, and internal factors related to interpersonal and communication factors. Firstly with regard to policies there was a political view that the psychiatric and social services should work closer together. However barriers to this were the professional views that each held about the service user group, whereby health staff were perceived to focus on the medical model of illness which was viewed as a deterrent to social integration, whereas social services staff viewed the service user as a partner and focussed upon the healthier parts of their functioning. This resulted in different professional – service user behaviours with psychiatric staff being more persuasive to motivate service users if they did not wish to participate in an activity, whereas social service staff accepted this as the service user's choice. Social services staff perceived their role to be less clear cut and one that involved the planning and co-ordination of services provided to the service user, compared to psychiatric staff, who had a clearer defined role in terms of being responsible for the service user; reviewing medication and patient care. Social service staff felt that this was because of their less experience overall in working with this service user group. Geographical location was also a factor with more collaboration in teams that shared the same building. However more important was the perception of a team spirit between professionals and a respect for each other's roles. This was enhanced when the care of service users was seen as a team responsibility rather than an individual team member responsibility. Lack of respect for professional competence reduced team working and collaboration.

Conflict

The meeting has an agenda which is followed in each meeting. The number of participants varies at each meeting but it is not uncommon to have between 12-14 team members present to participate in the meeting. With such a large number of people the need to control the meeting falls to the chair who invariably is the team manager. His main role is to manage the meeting to get through the referrals, new assessments, focus on the meeting outcomes and deal with any conflict that arises in the meeting. He does this adeptly when reminding the team about the study:-

“The team leader distributes the agenda for today’s meeting and introduces me to the group and asks if I need to have introductions of other team members. I am introduced to the third consultant psychiatrist who was present in last week’s meeting but couldn’t recall from a previous business meeting what my research is about. It appears that the psychiatrist is a little puzzled and bemused by my presence and the team leader maybe sensing this closes down any questions of communications by stating “ Angus is here because he is going a piece of research. He has got to complete this research”. He turns to the meeting agenda and begins”.

Conflict also occurs within the group at an innocuous level and is put over in subtle ways.

“The conversation turns to personal matters as the member of staff reveal that he is on holiday soon and that his partner is expecting a child and he expects to be in the maternity unit over the next week. As other team members file into the meeting and they are predominantly female they recount their experiences of pregnancy with the effect of embarrassing the CPN as he can expect to have no empathy for how his partner is feeling”.

I reflect that on discussing my study I look to avoid possible sources of conflict with some members of the team who may feel excluded due to the study design as this excerpt from my filed diary shows:

“I speak for about 10 minutes about my role and my motivation for the study and a brief description of the study and what participation will require. I head off potential conflict from other team members by describing why I am selecting mental health nurses for the interview and this seems to go down well”.

There are also examples when conflict can be overt within the team which can be handled quite differently with withdrawal on the one hand and acknowledgement and neutrality on the other. The following two excerpts demonstrate this:-

“the same CPN then throws down a challenge to me in that CBT therapist’s aren’t usually interested in BPD and these service users tend not to do as well in the therapy compared to other therapies such as psycho-analysis. The psychiatrist who is sitting to my left and been quiet in the meeting replies that they do “ statistically better in CBT compared to other service users such as those with depression as the BPD service user needs and values the attachment through the relationship”. The CPN agrees with this analysis and withdraws from the discussion”.

“There was mild dispute from a social worker regarding the prescription of diazepam “isn’t that contraindicated in someone who is prone to angry outbursts”
Psychiatrist: “there is some on going debate about it’s effectiveness, could go either way”

Norman and Peck (1999) define interprofessional working as health workers taking on the same tasks and performing generic roles. They highlight that the possibility for conflict is greater in CMHT’s than in other settings due to the variety of professional groups involved and their positioning for power within the teams. They describe four main factors associated with why professionals working in CMHT’s fail to comply with operational directives: loss of faith in the system that they work within; strict adherence to a uni professional culture, the absence of a strong shared philosophy of community mental health services, and a mistrust of managerial solutions to the the problems associated with interprofessional working.

Lankshear (2003) examined the factors underpinning service user allocation in a CMHT and the range of strategies that 6 CMHT’s used to cope with conflicts in service user allocation decisions. Using a case study method the author found that strategies used to cope with conflict were isolation, this occurred when particular team members took on service users with anxiety and did not feel anything in common with other team members (who worked with Serious Mental Illness service

users) resulting is isolation from the team. Resolving workload tensions through providing support to colleagues and valuing them as friends and colleagues was termed fraternisation. A third strategy was negotiation whereby there was a rota system in place for allocating new service users and this took into account existing workload patterns of team members.

Power

Power has been defined by Burr (2003) as a product of the culture and the actions that are permissible within that culture. The norms of the cultural group therefore are dependent upon the discourse generated within the group and refined between group members at successive interactions. Power relations between medical staff and the rest of the team have already been identified earlier within this analysis under the theme of “Getting Started” and the design of the team Performa to facilitate the meeting process. This illustrated with the following extract from my field observation notes:-

“There is some discussion from the medical staff about her GP which governs that he would see her for a psychiatric assessment and possible medication. She is allocated to a mental health worker for further work”.

The discourse in this extract appears to advocate the need for psychiatric assessment and the categorisation of the service user with a diagnosis which will lead to the prescribing of a particular type of medication. This description of the case will also lead to the allocation of a co worker within the team and the focus of this work appears related to medicines management. This would tend to suggest that a hierarchy of power (Warne and Stark 2004) is in operation within the team with a dominant medical discourse which may influence the work of the team and the decisions reached regarding access to services. According to Foucault (1984) power operates through social practice and this can be seen in the team by the nature of the

interactions of the team members whereby professional discussions relate to medical discourse about diagnosis which would appear to further influence the work of other members of the CMHT in reaching decisions about referrals. Roberts (2005) states that psychiatric discourses and their associated practices produce an individual's subjective identity and cite diagnosis as a prime example of this. Building upon this concept it would appear that the identity of the team is being shaped by this powerful discourse from the medical profession, and underlines the importance of their role in establishing diagnosis; service user allocation; geographical attachment of general practitioners who make referrals to the team; prioritizing the role of medication above other interventions; and enlisting other professionals ie CPN's to monitor the effects of medication and thus extending their power to determine the role of other members of the CMHT. From this perspective medical discourse significantly contributes towards the shaping of the identity of the CMHT.

A further example of the hierarchy of power within the team concerns an innocuous comment towards the fact that the researcher is wearing denim jeans during an observation period. The following excerpt is from a student nurse who can be thought of in terms of the hierarchy as having the least power within the nursing hierarchy. She is resentful that she is not allowed to wear denims:-

“As we wait for team members to arrive, one of the older women mentions in a low voice some comment about wearing jeans to work and states that they are expensive and good quality. She is referring to another team member and looks at me and I state that I am also wearing jeans today but that I can perhaps be excused as I am a student today. To which the student nurse intones “I’ am also a student and I’m not allowed to wear jeans to work!”

This comment appears to uncover underlying resentment by the student nurse that there is unfairness in how she is treated within the team. There is a tension in her account. The student nurse appears to identify with the researcher's description of himself as a student (in the field of research) and corresponding attire denoting a less

formal approach to his research participants. Perhaps there is some further resistance towards how she perceives her identity and how the team perceive this as in the presentation of self from a professional viewpoint. From a Foucauldian (1998) perspective (1998) where there is resistance there are power - knowledge relations at work and such forms of resistance as examples of individuals desiring to be a legitimate participant in that dialogue. Hence the student's remark can be understood as perhaps a passive participant within the decision making process or as someone who does not wish to assume the identity of a member of this team.

This example can also be viewed against a gender discourse where the consultant psychiatrists and team leaders are all men with the majority of the team comprising of CPN's occupational therapists and social workers comprise of women. The dominance of men in the team may result in inequalities in the workplace and this may also be used to explain the student nurses' reaction above. Could there be a subordinate role for women within the team? The student's comment was preceded by one of the women CPN's pointing out the wearing of jeans, could gender inequalities be a source of dissatisfaction within the team?

Examples of responses to perceived power imbalances in the form of humour have also been identified within the analysis. In the following example humour is used in the meetings as a further illustration of subtly denigrating the other professional's theory about a service user presentation. This is demonstrated below:-

Psychiatrist: “, is she emotionally blunted or is she like a lost little girl needing looked after?

Social worker: “I don't think I can cope with Mother twice a year”

In this excerpt the service user is a 47 year old woman with 17 year history of depression which has got worse over the past 2 years since she was diagnosed with Chronic Obstructive Airways Disease (COAD), and has found it difficult to adjust to

the physical limitations of the disease. She is a long term smoker and user of cannabis and alcohol. She has suicidal ideation and has taken an overdose feeling hopeless about living with her diagnosis. The psychiatrist attempts to make a psychodynamic interpretation as a way of developing an understanding of her presentation and which would also attempt to clarify the potential roles of team members in a limited re-parenting role to help contain her distress. This is resisted by the social worker who uses humour to undermine the explanation put forward. The decision of the team in this case is for her to see a psychiatrist in out-patients to review previous history; medication review and also link in with disease management.

Similarly humour can also be used to pressurise colleagues into the teams preferred course of action as the following example illustrates:-

“The final section of the meeting is for case reviews of existing service users. These may be related to particular challenges associated with the case for which it is useful to get a team perspective and is open to all team members and there is an allocated time of 5 minutes per patient. The chair asks if anyone has anyone to present and firstly a social worker states that she has someone. A consultant psychiatrist postures and says that he may have someone but he is rather complex and may take a lot of time, said in a rather apologetic manner. He is not encouraged by the team to pursue this further and they cut him off and inform him with a sigh of relief (from the team) that he is not presenting! There are no other takers and the social worker begins to discuss her service user”.

Griffiths (2002) found that humour was used to challenge the decision making of the group and also those in superior positions of power within the group, such as team leaders and medical staff. Humour was used in the above observations to challenge the doctor that his service user would take too long and he was censured in a non threatening way for attempting to bring a service user who would take too long, thus preventing the meeting from ending promptly. It is interesting that the discourse from the team towards medical staff is related to the resistance of their suggestions and as Burr (2003) suggests that knowledge and social actions go together as specific

constructions of the world are bound up in power relationships and these have implications for what is permissible and how people treat each other within the team.

7.3 DECISION MAKING FACTORS

I will now describe the factors that the CMHT considers in order to make a decision about whether to accept a service user into their service. These are subcategories which comprise the decision making category.

Stepped Care: Previous History of Interventions

Underpinning the stepped care approach to health care delivery is that service users should receive interventions at the least specialist level of delivery to determine whether interventions are effective before referring for a more specialist level of intervention. It is a form of health rationing. With regard to referrals to the CMHT, a least specialist level would be at primary care with services being delivered by the GP, counsellor, psychologist or primary care mental health worker. Referrals that have not been seen by practitioners at this level would not be considered by the CMHT and referrals would be sent back to primary care as the following cases show:

- “a male patient with low mood and has taken a recent overdose following the ending of a recent relationship. He appears to be impulsive and was referred 1 year ago but did not arrive at the assessment. He has been started on an antidepressant by the GP 1 week ago and it is too early for any effect from this. It is suggested that the GP monitor over the next month the effectiveness of the antidepressant and referred to see a counsellor in primary care”.
- “a woman with Post traumatic stress disorder (PTSD) and with little discussion it is unanimously agreed that she see a primary care psychologist”.

The following case shows that when the service user has had an unsuccessful outcome at the lower level of health care provision then the team consider that their service may be of use to the service user:-

“A 41 year old man with a 21 year history of fear of dying, with additional financial and work concerns. His extended family are going for 2 operations and he is also worried about the big bang collider and fears the end of the world. He has sleep apnoea and self harms though he does not wish to kill himself due to his fear. He

has seen a primary mental health care. A consultant wonders if he is a bit paranoid. He is offered an assessment by the CMHT”.

Stepped care according to Von Korff and Tiemens (2000) provides a framework for the care of people with chronic illnesses that uses limited resources to their greatest effect on a population basis. The model is based on three main assumptions, firstly that individuals with chronic illness have varying degrees of need which require different levels of care; determining the correct level of care depends on careful monitoring of the condition and outcomes and lastly moving from lower to higher levels of care based on outcomes results in increased effectiveness and lower overall costs. Arthur (2005) however cautions against the adoption of the stepped care model by highlighting some of the concerns of the model: having clear criteria for determining movement up and down the steps, that failure at a lower level may discourage service users from seeking help at the next levels, resulting in demoralisation of service users by subsequent treatment failure and that service user with complex needs should be seen at the specialist level without having to progress through the lower levels of the model. Stepped care viewed against these criticisms would appear to be a method of rationing healthcare without targeting need where specialist services would be the first rather than last level of intervention.

Presence or Absence of Risk

The category of risk is considered of paramount importance to the team when reviewing service user referrals and override concerns about the category of stepped care referred to above, as the following observations show;-

“A 34 year old man previously taking antidepressants and had stopped taking these now experiencing voices has no medical input and is currently distressed. He is offered a joint assessment”.

“This man with low mood, suicidal ideas impulsive, a family history of mental illness, is a knife carrier, who stabbed his neighbour; and has a history of self harm. He poses as a risk to self and others and a joint assessment is agreed”

McEvoy & Richards (2007) in a qualitative study of how service users access CMHT's in an urban area in the North of England found that there was a hierarchy of appropriateness which consisted of 5 different levels. Firstly service users were able to access a service depending upon the degrees of severity and risk which were dominant categories. Severity and risk were further sub divided into three tiers each consisting of diagnosis, level of functioning and social vulnerability. Service users with a diagnosis of schizophrenia would be found in tier one and almost always accepted into the service. Tier 2 diagnoses would relate to non psychotic diagnosis ie severe depression presenting with risk, and tier three would be for mild anxiety and depression. These would mainly be referred back to primary care. Risk would be the dominant criteria in decision making to accept service users into the service.

Additional categories of beneficence and morality were used in situations where there were more than one course of action. Beneficence was related to empathic & regretful feelings of the team to refer the service user to other services. However this was also related to the potential impact of short term support on the patient's problems. The moral dimension was related to the genuineness of the problems; and also with regard to a duty of care to the patient, for example in terms of their vulnerability. The authors also found several key contextual factors that influenced decision making along the above hierarchy and these included: fitting in with service strategic planning initiatives, for example teams being regulated via clinical governance and performance systems along the lines of the National Service Framework for Mental Health. Another factor related to burden of responsibility

which meant that clinicians would limit caseload size in order to reduce the likelihood of potentially serious untoward incidents from occurring. High referral rates and low turnover affected capacity of teams and therefore influenced access decisions. The position of the CMHT in the economy of care also influenced access, in that the CMHT would be more aligned with Serious Mental Illness in preference to Primary care meaning that those with more severe diagnosis and risk profiles would access the CMHT. Lastly the relationship between managers and clinicians affected access issues in that tighter boundaries surrounding the work of the CMHT in light of modernisation agendas had begun to emerge. CMHT service provision could be monitored against the service user tiers as described in the National Service Framework and working practices were changed so that service user access could be enhanced with delays for appointments being reduced considerably.

Controlling Workload Demands

The chair opens the meeting and asks for apologies and then proceeds with the new referrals. These are referrals received for the week and are handed to various members prior to the meeting to read out in the meeting. Referral numbers vary but they range from between 6 to 10 new referrals per week. In turn each member of staff is invited to read out their referral letter. This is followed by questions by the team members and ideas about the potential outcome of the case. Questions relate to the themes of missing data and documentation; about whether the service user is able to attend the team or whether a home visit is required, what range of treatments or interventions will work; guestimates at why the service user has been referred; and not related to the service users but discussion within the team about the range of

medical cover and who will be providing this cover. Following each “discussion” there is an intended outcome if the case is taken on for an assessment: who will be allocated to assess the case? Where this will be? Either the clinic or a home visit and therefore two staff will be required on safety grounds.

Throughout the observations I have seen many examples of referrals made to the team where there is insufficient information to guide the team to make a decision and this is followed by request to the referrer for additional information which subsequently delays from the service user perspective the time to see a mental health professional:-

Service user 1: A lady with OCD and agoraphobia who has recently been suicidal and been seen by the crisis team and who are now referring onto the CMHT for additional work. There is an additional complication in that she is being investigated by the police for making exaggerated complaints against her boyfriend. “what does the CATT team thinks she needs?” inquires a CPN. The decision is to **request more information and liaise with the referrer.**

Service user 2: A 47 year old woman with low mood and increased alcohol intake and risky disinhibited behaviours particularly when cooking. She also feels ashamed and embarrassed about her behaviour. She has been seen by primary care mental health worker (PCMHW) and there is no improvement. Medical staff feels that she may have features related to the deviant categories of BPD or Bipolar Affective Disorder an assessment may be useful but after further information is obtained from the PCMHW on her behaviours and alcohol intake. **Decision:** further information.

There are also many examples of referrals being referred back to primary care to be seen by a member of the primary care team staff or other professionals who are located within primary care, such as psychology staff. These decisions occur at the referral stage before the service user has been seen by the members of the CMHT. These approaches for processing referrals are illustrated in the next paragraph where the referrals are all from General Practitioners (GP’s):-

- Service user 3: appears to have a health anxiety with limited coping strategies, she poses low risk and is referred back to a primary mental health worker.

- Service user 4: has a history of abuse and has received the service of the Crisis resolution and home treatment team who has referred back to the GP with a recommendation that she be referred to the CMHT. There is some confusion as to why she was not directly referred and an action point is to discuss with the crisis team. Despite this it “sounds like counselling”.
- Service user 5: a male patient with low mood and has taken a recent overdose following the ending of a recent relationship. He appears to be impulsive and was referred 1 year ago but did not arrive at the assessment. He has been started on an antidepressant by the GP 1 week ago and it is too early for any effect from this. It is suggested that the GP monitor over the next month the effectiveness of the antidepressant and referred to see a counsellor in primary care.
- Service user 6: a woman with post traumatic stress disorder (PTSD) and with little discussion it is unanimously agreed that she see a primary care psychologist.
- Service user 7: woman with obsessive compulsive disorder (OCD) and may also have Aspergers syndrome. The referral is for confirmation of diagnosis. The consultant is to discuss with the GP for additional information

The above discussions occur at each meeting, this appears to be the standard process for dealing with service user referrals, with a filtering process being implemented at the new referral stage which seeks to identify those who at most in need of the services of the CMHT and those who can be held by other parts of the mental health pathway be it in secondary care with the CATT team, or in primary care.

Some support for current practice can be found in the study of referrals to CMHT's over a 6 month period to investigate the effects of 3 gateway workers providing a triage role on referrals to the CMHT, Ryan et al (2007) found that 8% of referrals were taken on for enhanced CPA which may suggest that the majority of service users referred do not require the specialist service of a CMHT. Dispersal of service users showed that 48% received input from the gateway workers with 15% being referred back to primary care and 46 service users were referred onto the CMHT secondary care team of which 23 were accepted for a service.

Griffiths (2002) using a discursive approach to examine how CMHT's categorise service users referred for a service, identifies three methods that CMHT's

utilise in reducing the work pressures of the team. She relates that CMHT's buffer the referrals by firstly recommending a less intense intervention delivered by a professional in primary care, or other part of the service; and delay the referral by requesting additional information from the referral. With regard to the above service users there are examples of service users being referred back to be seen by a worker in primary care and service user referral being delayed but requesting additional information. A third strategy used to reduce workload is to challenge the referral by asking the referrer to reconsider the referral. Service user 5 and 7, following additional discussion with the GP may come into this category.

This decision making process about which service users will be offered an assessment and ultimately a service will be explored in more detail when the analysis examines the interactions within the team and these ultimately influence how service users access a service from the CMHT.

Henderson et al (2008) found that conflicting disciplinary priorities led to difficulties in communication and co-ordination of care across disciplines which contributed to tensions in determining specific disciplinary roles and resulted in an increase in workload for nursing staff. In a study to determine the factors that influenced workload in CMHT's in South Australia, the authors found that increasing workload was related to staffing levels of the team with workload being exacerbated by covering the caseload of absent colleagues, for example from sickness. This is currently present in the CMHT with a team member off on long term sick resulting in weekly discussion and allocation of her caseload which also results in the team having one less member to take on going referrals and increases the workload of other team members.

Service user characteristics were the biggest factor and included (unwell) service users discharged from an acute ward and who still experienced significant levels of distress and acuity with rapid changing of needs. These expectations for recovery are at odds with the Department of Health's (2006a) best practice statements for the work of Crisis Resolution and Home Treatment Teams in the England which expand the concept of acute care by indicating that service user discharge should occur at the earliest opportunity when stabilisation of the immediate crisis begins. Other service user factors affecting workload included substance misuse, loss of insight, non compliance issues; disruptive behaviours such as aggression, and service users from culturally diverse backgrounds. From a systems perspective workload was increased by lack of integration between services with most of the work falling on CPN's to complete. Lack of standardised documentation across teams led to an increase in workload as did the emerging amounts of paperwork encountered by the CPN's.

Relating this to the CMHT in this study, additional workload is generated by the repetitive communications between the CMHT, the referrer and other service providers, which lengthens the time the service user waits to be seen by a mental health worker. Simpson (2005) observes that this is more likely to occur in CMHT's that do not have clear policies in place with regard to eligibility criteria for referrals to the service.

Coincidence of Presentation with "Familiar Categories"

The categories used to classify referrals within the CMHT relate initially to psychiatric diagnosis with regard to the serious mentally ill ie those with schizophrenia; bipolar disorder and also those which relate to increasing areas of risk ie major depression and suicide ideation. These categories mirror the dominant

professional discourse within the team ie medical diagnosis. However those dominant categories which appear to lie outside this spectrum would appear to rule out an assessment by the CMHT

“A 19 year old man being transferred from CAMHS. He has Attention Deficit Hyperactivity Disorder (ADHD), which draws the comment from a CPN “don’t know that to do with this.” A consultant states that “it is a bit thin on mental health issues” anxiety and depression are ruled out from the letter. There is a dispute between this team and referrer about who should take this case on and the decision is to refer to the team manager to look into and sort out. This also illustrates the comparison with this sort of service user and the “norm” for the team in terms of mental health problems seen.

Griffiths (2002) drawing on social labelling theory of Hester (1992) to identify the categories utilised by community nurses and social workers to help make sense of service users and further help to prioritise their needs. These categories relate to culturally available forms of deviance ie “mad”; those where type characterisations are made, ie schizo-typical; those where attributes are culturally associated with the deviant category, ie voices; behaviours that are culturally associated with the deviant category, ie non compliance; comparisons with the norm; and invoking additional general categories such as trouble or problem.

This is a good example of a deviant category which is out with the remit of the CMHT. That is they would see the service user if they had a mental health related deviant category such as anxiety and depression and not rule out the service user on the basis of the ADHD deviant category as long as they have a mental health related one. However in the absence of a mental health deviant category the team would exclude this service user. However an added complication is that service users referred from CAMHS who have long term problems need to be supported by working age adult services and the team are concerned that a protocol may be in place that means they have to take the service user on. There is lack of clarity in how to support or help such service users.

However an assessment may be offered in those cases where the dominant category is unfamiliar as long as familiar categories are present which would possibly indicate a role for the team in the care and management of the service user:-

“A 19 year old woman with autism spectrum disorder being referred from CAMHS. She has a “pervasive developmental disorder” and has also been assaulted and has PTSD type symptoms (**deviant category**), with anxiety and depression (**associated attributes**), with above average IQ (**comparison with norm**) but as a consultant remarked could have Aspergers syndrome (**type category**) with the other consultant commenting that she is rigid and resistant (**associated behaviours**) and that her anger (**behaviour**) could be related to a emotional unstable personality disorder (**deviant**).A CMHT worker comment sounds like trouble (**general category**). The decision is to offer an assessment as this seems an interesting case and see what is going on.

This case also illustrates familiar deviant categories that the team have experience of, and represent the dominance of diagnostic categories, suggesting that access to the CMHT is dependent upon these culturally determined diagnostic categories. It is therefore uncertain how the CMHT deals with coexisting diagnoses such as BPD. There is interest in arriving at a diagnostic formulation of the case and there also seems more team involvement in the discussion about possible needs. All of Hester’s categories are used and shows familiarity with the categories. Again those falling outside the familiar culture of the team can evoke the following response;-

“in an earlier meeting one of the CPN’s remarked of another referral “we don’t diagnose Aspergers syndrome here!”.

Possibility of Other Mental Health Provider Input

When other specialist mental health providers are involved in the care but refer to the CMHT to take over the care of the service user there is some suspicion as to whether the CMHT should take the case on. This usually results in a delay with the referral to

find out additional information about the role of the cmht in the case, as illustrated below:-

A lady with Obsessive Compulsive Disorder and agoraphobia who has recently been suicidal and been seen by the crisis team and who are now referring onto the CMHT for additional work. There is an additional complication in that she is being investigated by the police for making exaggerated complaints against her boyfriend. "What does the CATT team thinks she needs?" inquires a CPN. The decision is to request more information and liaise with the referrer.

In a retrospective study of how consultant psychiatrists, junior doctors and CPN's prioritised referral to four sectorised CMHT's, McEvoy et al (2002) found that consultant psychiatrists mainly seen service users with a diagnosis of psychosis who presented with higher risk compared to those seen by CPN's and junior doctors. Access to ongoing support of the team was broadly similar if service users were assessed either by a consultant psychiatrist or CPN. Types of support provided varied from ongoing support characterised by more than 3 follow up appointments with a mental health professional; crisis support was defined as three or fewer contacts. Additional approaches used by the team included referral to another service ie substance misuse, and referral back to GP for alternative therapeutic management. Service users with psychosis were more likely to be provided with ongoing support and service users with a diagnosis of personality disorder were offered crisis management approaches. CPN's referred more service users to specialist substance misuse services whereas these service users would be seen by the CMHT if assessed by medical staff, whether it was a consultant or junior doctor who made the assessment.

According to the CMHT Policy Implementation Guidance (2002a) there are three distinct functions of CMHT's: to give advice to other professionals in the management of those with mental health problems ie primary care. The provision of

interventions for those service users that can benefit from time limited interventions, and also to provide care and treatment for those service users with more complex and enduring needs. Within these functions there is a hierarchy of need with the majority of the team's focus to be spent on those with more complex need and may explain the actions of the CMHT in referring service users back to the GP when they have not been seen by the primary care mental health worker/ team.

This hierarchy of need also appears to be operating within the context of access to social care provision for service users with mental health needs, the Fair Access to Care approach was established to ensure that service users were eligible to access social care provision as part of their package of care. According to the Department of Health's guidance (2002) on eligibility criteria there are 4 main criteria. The uppermost band is referred to as the critical band and is when the service user is unable to perform social care routines in order to maintain their independence and may require institutional care or have a serious and detrimental impact upon the local community. The substantial band relates that service users may have substantial risks to independence and greatly threatens their independence. Moderate and low bands relate to minimal impact on threats to independence and are unlikely to qualify as eligible for social care services. Cestari et al (2006) found that such judgements about eligibility and priorities differed between health and social care staff leading the authors to conclude that this together with the lack of preventative services available resulted in inequity of service provision across local authorities and contrary to the integration ideals set out in the Mental Health Policy Implementation Guidance (2002a), and actually served to reinforce a separation of mental health and social care service provision. In a qualitative review of the same study, Huxley et al (2008) noted that when CPA judgments were compared to FACS criteria that there were

differences in judgment about allocated group with CPN's and occupational therapists allocating one fifth of those with low social needs to enhanced care co-ordination. Around 36% of those with enhanced care co-ordination were adjudged to have low social needs. This led the authors to conclude that comprehensive training should be provided to healthcare staff in undertaking social assessments as the health professionals could not differentiate between critical and moderate needs on the FACS criteria with the former being the level that provided access to services. The authors acknowledge that assessors may have used gaming strategies to enable those with moderate needs to have access to services. However in relation to this study it may be that CPN's discourse is dominated by the biomedical model rather than a social or recovery based model resulting in less emphasis on assessment of social needs.

7.4 DECISION OUTCOMES

Service Offered

Following assessment the offer of a service is very similar to the factors associated with the decision to offer an assessment as described above. The categories associated with this are related to increasing risk, clear goals and specific roles for professional involvement, no improvement from stepped care or the least specialist involvement and availability of defined categories. This is briefly illustrated with respect to Hester's (1992) categories in the following example:-

“A 45 year old man presenting with clinical depression (**deviant**) suicidal ideation who was distressed and tearful (**attributes**). In addition he was diabetic and neglecting his diet and had also sent away to the USA for a needle kit which he was intending to use to kill himself and his 2 dogs. He also has some avoidance of leaving home except with his dogs. (**Behaviours**). He also has housing needs and has been unable to get his own house due to being unable to take his dogs with him. He had been referred to CATT (requests for other services) but they didn't think he needed their intervention. There was some **dispute** about whether he should be taken on with a social worker commenting “there are holes in his story, and he can leave home when he needs to” seemingly making the connection to the

service user's attributes of control. The consultant highlights the needs of the patient by highlighting that if "we referred him to CATT then at least we think his risks are significant and on that basis we should then take him on even if they don't". Additional risks related to the neglect of his diabetes and his suicidal ideation are connected by a CPN to further highlight his needs and care goals to improve his self care and manage his diabetes. His housing needs were also identified and together with the need to provide a "stabilizing hand" and review his medication from one of the consultants, **goals** are established and the role of consultant and nurse are beginning to be established. The role of day services are also suggested and the service user is accepted on to be offered a service by the CMHT.

Service Declined

Conversely service users not accepted following an assessment are related to the categories of low risk; having a non mental; health related category such as Aspergers Syndrome; other agency involvement that would duplicate service provision or stretch the team in terms of insufficient capacity to meet needs as in the case of a service user with 5 children all subject to child protection procedures.

With regard to the diagnosis of borderline personality disorder, a service is not offered when severity of risk is low and distress associated with the disorder is minimal.

"A 28 year old man with a referred diagnosis of BPD with a history of and on going self harm; alcohol abuse of a significant nature, He is not suicidal or psychotic He is known to the service and the team request his previous medical notes with the goals for the medical staff to review his medical history and medication with a view to him being seen in primary care by a primary mental health worker".

In Ryan et al's (2007) study of the effectiveness of 3 gateway workers providing a triage role on referrals to the CMHT, the authors' found that although the team were referred 471 service users only 3 had a diagnosis of personality disorder and 10 or 2.1% had a diagnosis related to severe mental illness. At time of referral 37% did not have a diagnosis. Despite these low numbers for personality disorder 13.6% of referrals had an identified risk of self harm suggesting that personality disorder may have been more widely

distributed than first thought, or that the diagnosis of personality disorder is poorly understood amongst these gateway workers.

7.2 Reflections on Observation Phase

A total of 5 observations of the CMHT referral and assessment meeting took place. The discourses associated with the referral meeting had several influences which shaped the decision making of the meeting. Primarily medical discourse dominated the meeting in that the structure of the assessment proforma was related to which psychiatrists covered the service users' GP. Decision making following assessment was often related to the medical model of intervention ie the selection of appropriate medication and this largely determined whether service users would be offered a service. The role of medication often determined the nurses' role in that they would monitor medication for both efficacy and side effects.

Discourse associated with mental health nurses and social workers related to the ongoing monitoring and surveillance of the service users for risk assessment and management together with the demands associated with the care programme approach and the role of the care co-ordinator which these professional groups undertook as part of their day to day work, resulting in a blurring of their roles. It was however uncertain what other skills and approaches that the CPN's would need to utilise with service users with BPD in order to maintain their therapeutic engagement.

Categories of service users taken on for a service mainly related to the familiar categories of severe mental illness or other axis 1 disorders, and had already seen a professional within primary care services. These familiar categories together with the taken for granted roles of professionals within the team were more likely to result in service users being offered a service when there was team consensus on the categorisation where the presentation could be linked to familiar features associated

with the category together with some rudimentary explanatory framework for understanding the presentation. It was however unclear as to how the CPN's engaged with the diagnosis of BPD and how they understood service user presentation and need with respect to the recovery model and how this would influence their interventions.

Unfamiliar categories together with those presentations which resulted in dispute within the team were not immediately taken on by the team and referred to other services, or additional information would be requested before making a decision. This had a negative impact upon teamwork together with an undercurrent of unresolved conflict between the professional groups which were handed to the team leader to resolve usually with the external referrers.

Despite the large number of referrals to the CMHT there were very few service users with a diagnosis of personality disorder referred to the team and decisions to offer a service was related to the stepped care model, their level of risk or whether they had recent been discharged from hospital which would then become a priority for the CMHT to provide aftercare for such categories of service user. It was unclear however how the CPN discourse associated with monitoring and surveillance would link with the development of therapeutic relationships and manage the possible tension of developing recovery orientated approaches with service users as the medical model was mainly articulated and expressed throughout the observation period.

It was also unclear how individual CPNs understood their role with regard to longer term involvement with service users with a personality disorder as the main thrust of the assessment meetings was in signposting service users to relevant agencies and focussing their interventions to their dominant discourse ie prescribing

and surveillance. It was also unclear whether the CPNs' focus of risk assessment and management would be conducive or counterproductive to the development of hope and optimism inherent within the recovery approach, and how would the individual CPN's negotiate this with service users?

Service users with BPD have previously been categorised as difficult by mental health nurses and by its very definition BPD is characterised by unstable patterns in interpersonal relationships. The interpersonal tensions that may occur when working with BPD are qualitatively different to those that occur when working with familiar categories such as schizophrenia or bipolar disorder where the emphasis is upon withdrawal from professionals and interventions. It is unclear from the observation phase how the CPN's will manage these potential disruptions to the therapeutic relationship and maintain therapeutic engagement during emotional instability expressed by the service user with a diagnosis of BPD?

As a result of the observational phase of this study the discourse associated with the CMHT has become better understood. The culture of the CMHT appears to be primarily shaped by the medical hierarchy of the team; psychiatric discourse and the possibility of a gendered discourse within the team. In addition the observation component highlighted the complexity in attempting to achieve inter professional integration and working within the CMHT and how the CMHT members negotiate the inherent tensions of working in the CMHT. These relate to the tensions of professional roles and models of intervention set against the dominance of the psychiatric discourse and the establishment of diagnosis and treatment interventions which may be at odds with individual practitioner preferences. Therefore the domination of medical discourse highlights the tension within the team between this and their own professional discourses. Such tensions within CMHT's have been

reported to lead to further conflict and fragmentation within the CMHT (Heginbotham 1999) Individual team roles were another source of tension and the allocation of cases often underlined the nature of the team being more akin to individual practitioners than offering a team approach to their service users. This in turn contributed to a further tension in determining at this stage through the observation of whether the team was operating as a specialist mental health team or of a more generic team? Psychiatric discourse also dominated the decision outcomes for service users and these related to the familiar categories of the CMHT related to psychiatric disorders such as those with schizophrenia, major depressive disorder; bipolar disorder, those related to general syndromes such as anxiety or personality disorders with their specific subtypes; as well as those categories which relate to presentation for example self harm; suicide ideation or a service user who had stopped taking medication and was now hearing voices.

What was less clear and would be important to explore within the context of the ethnographic interviews was how the CMHT and CPN's in particular categorised and constructed the individual with the psychiatric diagnosis of Borderline Personality Disorder. Referrals of such service users during the observation phase had been low with one service user being referred and being declined access to the CMHT due to the low risks and the need to have him seen in primary care due to these low risks. The interviews would also help to understand how the CPN's negotiated the tensions inherent within psychiatric diagnosis and a recovery focussed approach and how this influenced their therapeutic approaches with service users and in their professional relationships with colleagues.

These tensions have become the frame of reference for the ethnographic interviews with individual CPN's to help articulate how the CPN's construct the

diagnosis of BPD and how they manage therapeutic engagement with a complex service user group and promote recovery focussed approaches with service users. These issues relates to the following questions that were used in the ethnographic interviews with the CPN's:-

- Q1) How do you feel about the diagnosis of BPD?
- Q2) How do service users with BPD access the CMHT?
- Q3) What is the role of the CPN when working with BPD?
- Q4 Tell me about the needs of the service user that you are working with?
- Q5) Tell me about engagement with your service user.
- Q6) What is the recovery focus with the service user.
- Q7) what would make you work better with a service user with BPD?

8. First Round of Interviews

8.1 Introduction

The aim of this analysis is to inquire into how the CPNs socially construct the identity of the service user with a diagnosis of BPD both within their clinical contact with service users and with team members of the CMHT. Seven main categories emerged from the interview data collected in the study and these are shown in table 2 below and will now be explored in more detail.

KEY PHASES OF ENGAGEMENT	ELEMENTS
8.2 PRE-ENGAGEMENT	<ul style="list-style-type: none">• ACCESSING THE CMHT• REACTIONS TO DIAGNOSIS• ADJUSTING TO DIAGNOSIS OF BPD
8.3 SERVICE USER PRESENTATION	<ul style="list-style-type: none">• INTERPERSONAL DEPENDENCE• SELF HARM• OVERWHELMED
8.4 CPN UNDERSTANDING OF PRESENTATION	<ul style="list-style-type: none">• CONSTRUCTION OF PRESENTATION
8.5 ENGAGEING BPD	<ul style="list-style-type: none">• ENGAGING SELF HARM<ul style="list-style-type: none">• DISENGAGEMENT• ENGAGING OVERWHELMED• ENGAGING INTERPERSONAL DEPENDENCE
8.6 CPN'S EMOTIONAL REACTIONS TO ENGAGING WITH BPD	<ul style="list-style-type: none">• HELPLESSNESS• FRUSTRATION• ANXIETY• LIKEABILITY OF SERVICE USER
8.7 RECOVERY FOCUS	<ul style="list-style-type: none">• NORMALISING• NON STIGMATISING INTERVENTIONS
8.8 ORGANISATIONAL FACTORS	<ul style="list-style-type: none">• TEAMWORK• CPN WORKLOAD• SUPERVISION• WORKING BETTER WITH BPD

Table 2: Categories associated with Engaging BPD

8.2 PRE-ENGAGEMENT

Accessing the CMHT

CPN 1 in his first interview categorises the criteria for service users with a diagnosis of BPD to access the CMHT. He legitimises their need for access related to emerging psychiatric crises and how the CMHT can intervene (CPN1,Interview1, Accessing CMHT,Reference1):-

"But I just think anybody who's got an acute psychiatric crisis, you look at them, you look at the hierarchical problems and you look at what's the most emergent problem, how can you treat it"

In this account the CPN responds in terms of the selection process that was very much in evident during the observational component of the study. The language use is of a general nature which may in part be related to the nature of the question although with respect to a specific label such as BPD one would expect a response to include specific risks in terms of self harm and attempted suicide as well as significant interpersonal needs. It may be that the use of such language is an indication of knowledge gaps with respect to BPD and it's management.

CPN 2 enlarges the criteria used to access the CMHT in terms of emerging risk, functioning and level of needs (CPN2,Interview 1, Accessing the CMHT, Reference1):-

"I guess its things like looking at risks, the amount of risks there are, looking at the level of disability that they may have, and considering what their needs are and whether we can kind of address those needs, so it's seeing whether they kind of perhaps meet the bar in terms of their level of need."

CPN 2 attempts to articulate the level of risk within the individual and whether it is of a significant nature to meet the threshold set by the CMHT. His discourse also contains references to levels of disability and functioning, with a matching of needs to service provision. In addition the CPN sees the role of the CMHT in taking on service

users with BPD as providing a transition to other services and therefore in this role, the CMHT would appear to validate the service user experience (CPN2, Interview 1, Accessing the CMHT, Reference 2):-

"Bearing in mind you know where they are in other services, whether it was a transfer from another service or things like that to kind of bear in mind as well. Or, indeed whether taking them on will help them access other services as well, so in a sense there might be an opportunity for an advocacy role here that might help them to get psychotherapy or other treatments or that kind of thing so it might be a facilitative role."

Within this account is the other function of the team to take referrals from other sectors as for example when service users move locality. This also highlights the main function of a traditional CMHT that of identifying needs and signposting to other services. The CPN's account of the criteria to access services is related to a wider category of enduring mental illness which by its nature is a vague but however inclusive term delineated only by time (CPN3, Interview 1, Accessing the CMHT, Reference 1):-

"I think from what I can gather, and I'm fairly new to this, but from what I can understand is, if you've got an enduring mental health diagnosis then that fits the criteria for this service and that you are able to work on a longer term basis to help people"

This diagnostic criterion whilst appearing to be fairly inclusive can also be viewed as a catch all criteria in terms of mental illness actually discriminates against those with alternative diagnoses. In the case of those with BPD they usually have difficulty in accessing the service as they are considered not to have a mental disorder, though their experience is of an enduring nature. This can be viewed from a social constructionist perspective where the dominant discourse associated with mental illness governs the behaviours of teams into accepting only those service users with familiar labels and permits the professionals to work only with those service users.

The CPN further explains the relationship between BPD and her category of enduring mental illness and how this works to access the CMHT (CPN3, Interview 1, Accessing the CMHT, Reference 2):-

"When I say longer term I mean 1 – 2 years and I think that personality disorder does fit very well, however I think you need to have to learn extra skills I think whereas you're good at being taught better with the bog standard kind of diagnosis and I think we've gone a little bit behind on the personality disorder.

In this account the CPN explains that when working with this category of service users there is a need to develop additional skills and that there have been a skills gap occurring within the CMHT. In addition there is the emergence of an educational and service gap in meeting the needs of this service user group. The CPN states that when caring for BPD, they need more long term approaches for up to 2 years yet there is the suggestion from her account that the service is way behind in meeting this implying that both service managers and professional staff collude with this lack of investment to meet workload pressures rather than having adequate time in caseloads to meet this service user group's needs.

Reactions to Diagnosis

In contrast to this legitimisation of the label of BPD, CPN 1 provides some evaluation of the label from the viewpoint of his experiences with staff working on the adult acute ward (CPN1, Interview 1, Staff reactions to Diagnosis, reference 1):-

"it was used very much in a dismissive term on the ward, very much as a negative term"

In this account there appears to be a historical trend to the data in that the understanding of the term BPD had been understood from the perspective of ward nurses and this appears to be primarily from a position of negativity which implied that staff reacted negatively to the term BPD. The CPN states that it is used as a

dismissive term by ward staff. It is said to have negative connotations. It could be argued however that the effects of being dismissive is not to take one serious which may call into question the perception of genuineness of the experiences of the service user and the negative term is a pejorative label applied to the service user with BPD. The effect of this label, to dismiss their authenticity may also be understood by way of them being excluded from social participation within the ward setting. Perceived or enacted exclusion from social participation according to Kitwood & Bredin (1992) re-examples of stigma and the erosion of personhood. The stigmatising effects of the label of borderline personality disorder is evident as viewed from the perspective of staff working within adult acute in-patient settings can also be understood with respect to the writing of Young (2009) who links stigma with moral panic. For such reactions to occur there needs to be actors and reactors, nurses and service users with BPD in the above extract. The actors take a moral and judgemental stance towards BPD resulting in labelling and the process of deviancy amplification further attention is focussed upon the negative characteristics of the individuals setting up a self-fulfilling prophecy amongst the actors and reactors. This is further elaborated by the CPN (CPN1, Interview 1, Staff reactions to Diagnosis, reference 2) :

"Oh no, not another borderline personality," which automatically put people off,"

This phrase illustrates the relationship between the ward staff's evaluation of the diagnosis and their subsequent helping behaviour. The use of the word "*automatically*", illustrates the strengths of the reactions of staff to the diagnostic label, as though staff when categorising service users in this way followed some internal rule which prevents meaningful engagement with these service users. This is an example of situated speech as a form of social action. The effect of being put off

may be a further example of the moral indignation of the more powerful group (mental health nurses) towards the less powerful (service users) with the result of further exclusion from therapeutic care. The negativity surrounding the diagnosis was further constructed by CPN 2 (CPN2, Interview 1, Staff reactions to Diagnosis, reference 1):

"I think the initial feelings are one of – I think it's a very negative diagnosis, you know, the whole term feels kind of negative and that's always what's kind of strikes me about it".

What is striking across all three respondents were the universal support for the negativity and antipathy towards the diagnosis which was clearly located within other mental health nurses in other settings but also contrasted from their own beliefs about BPD. This implied potentially three processes. Firstly that the stigmatising effects of the label itself predisposed some staff to react in a particularly negative way which would have an effect on these service users accessing the CMHT by being able to get past the first filter and gain an assessment. Secondly that such reactions may be service specific characterised by the frame of reference adopted by CPN1 which was to clearly articulate the limited knowledge of those staff working within the in-patient services as a causal factor in their reactions, and thirdly that there is a process whereby the CPNs adapt and adjust to the diagnosis from a negative to a positive perspective toward the diagnosis, and also from a judgemental to acceptance of the service user.

Adjusting to the Diagnosis of BPD

(CPN1, Interview 1, Adjusting to BPD, reference 1):

"I used to be uncomfortable about self harm but now I understand it more, I don't shriek when I see it"

In this extract CPN 1 explains the relationship between extremes in behaviour such as self harm and his own emotional reactions and that he has become more comfortable and accepting of this behaviour due to his increased understanding of the function of the behaviour. The emerging construction from this account is that the CPN who is reflecting on his in-patient experiences where the dominant ideology is one of biological psychiatry with the main emphasis upon control of symptoms and elimination of distress. This results in intense emotions when the expression of emotion occurs as in the case of self harm. In this context the expression of self harm is viewed as a symptom to be controlled.

This construction continues (CPN1, Interview 1, Understanding BPD, Reference 6):

“to express themselves and the only way they could communicate with me at that point would be to relieve themselves of pain, would be to harm themselves or to have high risk behaviours, you know, very unstable emotional characteristics and a need for acknowledgment and listening...”

In contrast this account clearly identifies the function of self harm as a method of communication, to convey the distress that the service user is unable to verbalise to the nurse, and as a way of developing a relationship and being validated by other people. In this account the CPN is able to look behind the behavioural manifestation of distress and attempt to understand the reasons for the self harm.

Contrasting this with his explanation of how others, perhaps less well informed make sense of the behaviour (CPN1, Interview 1, Understanding BPD, Reference 4) :-

“you know, in other words, they cut themselves and they cope with *inverted commas* demand attention, you know, which is a typical practical but not educated view of the topic”

These two accounts of self harm behaviour illustrate both a collaborative and engaging approach as espoused by the CPN and a disengaging avoidant approach

from a less understanding position. In the account above the stigmatising evaluation of healthcare staff towards BPD is evident in that the reason for self harm is to gain attention which usually results in both a reduction of attention from staff and an increase in self harm as a consequence of this. Thus staff's model for explaining interventions is that a lack of attention should reduce the behaviour actually can lead to an increase in the behaviour. One aspect of adjusting positively to the diagnosis of BPD is the role of education and of being able to successfully apply this within the clinical field. These juxtapositions are neatly summed up by CPN1 (CPN1, Interview 1, Understanding BPD, Reference 6):-

“So that it my understanding of the diagnosis, but you know I have since read a lot more about it and I am fairly well rounded on the subject, but it's still a negative term, that's my view of it, but I don't view it as a negative diagnosis now. I don't switch off from the diagnosis like that anymore. I used to because I didn't understand it but since I've been in the community I'm more open to it and I understand those terms more clearly and I don't switch off.”

In this extract the CPN shifts his frame of reference between how he used to be when he was less experienced and how he is now. He relates that he is well read on the subject and his use of the term “rounded” may suggest that he has an understanding of the term from a variety of viewpoints. This “rounded” understanding from the CPN's perspective would tend to support his view that the diagnosis is still viewed in negative terms by other professionals. He acknowledges that this was his previous construction but appears to infer that he is now more in tune with the diagnosis by his use of the term “open to it”. This discourse would appear to illustrate a shift in perspective from the CPN which he attributes to two key factors, firstly his increase in knowledge describes above and secondly, by now working in the community he perhaps has developed his expertise in working with this service user group perhaps in a different way from that of being a ward based nurse. Another interpretation is that

he is also developing alternative constructions by being in a community team which may be more multidisciplinary in nature compared to an in-patient ward, and thus captures more descriptive than dismissive accounts of people with a diagnosis of BPD.

It would therefore appear that from this CPN's perspective the role of experience and knowledge above are cited as key constructs in being able to adjust to working with people with a diagnosis of BPD. The role of education has been highlighted by Wright et al (2007) as being an essential element in deconstructing professional discourses associated with negative labelling of people with a diagnosis of BPD. There is also the suggestion that the locus of the team ie community is proposed as a reason for adjusting to the diagnosis and that perhaps additional categories of mental disorder are available to the team. The community perspective therefore may provide a thick (Gillman et al 2000) or description rich account of BPD compared to thin accounts afforded by the restricted view of BPD in inpatient accounts at the level of behavioural expression. However despite a range of educational perspectives stereotypical views of BPD continue (Wright et al 2007). The effects of limited experience and knowledge are linked together in CPN (3)'s account of how previous exposure to this service user group affected her (CPN3, Interview 1, Understanding BPD, and Reference1):-

“I would say that I've grown wiser within my nursing career and I suppose I've gained the skills and the knowledge to be able to make better judgements, but I must admit it is a disorder where I've found it extremely difficult to nurse somebody, because you weren't quite sure what would be the best way to help them with that diagnosis, so I felt a bit helpless and lack of understanding.

In this account the CPN identifies the coexistence of both skills and knowledge and the assertion is that one exists in the presence of the other. This can be linked with the openness of the previous CPN to the disorder and the need to actively seek out

experience with this service user category in order to develop expertise and thus adjust from a previous stereotypical perspective. The account also contains the term diagnosis suggesting that perhaps the openness of CPNs to the category is because of the permissiveness of the term by the medical staff who lead the team. The account also links emotional expression and beliefs with uncertainty about managing the case and is clearly linked to a knowledge gap.

Thus the degree of understanding into the diagnosis would appear to be an important determinant in developing meaningful engagement approaches and thus facilitating recovery for the service user. This will now be explored in more detail.

8.3 Service User Presentation

Questions related to service user presentation were used to explore current cases that each of the CPNs' were currently working with and who had a diagnosis of BPD. Their presentation was explored to better understand how each of the CPN's worked with the service users and to determine how they approached their initial focus and negotiation of initial goals with the service user.

The Interpersonally Dependent Service User with BPD

CPN 1 was working with a male service user who was in his late 50's originally from Cumbria and was well known to the CPN and had care co-ordinated him before. He had currently taken him on as his care co-ordinator was on sick leave and the CPN was "looking on" for her until she returned to work. The following excerpt provides a useful summary of his needs (CPN1, Interview 1, Service User Needs, Reference 2):-

"I looked after him as a care co-ordinator for about 18 months a few years ago then he was discharged because he was doing very very well and we thought that there was a dependency problem creeping in and I put it back to him and said, "Are you coping very well?" because he had been treated for depression and neglect. He wasn't detained and I took him to a hostel originally, but that's all by the wayside now because he's now in his own property. I got him set up with a flat through the hostel and I discharged him, but we picked him back up through an assessment because he was having real difficulty with

suicidal thoughts and risk and he was threatening to services he was going to do this, do that, and the other and he couldn't cope and he needed somebody to help him. Lots of stuff with physical health, he has bad legs, a bad stomach, he's had prostate problems, so he's got numerous physical problems which are always being investigated.

In this account the discourse is initially focussed on the service user's dependency and this is initially clarified by the CPN in terms of the service user's coping ability. The main interventions are related to re-housing and an explanation for the dependence is provided for in terms of the service user's stressors which he finds difficult to cope with. This service user in addition to BPD also experiences depression which results in him neglecting his personal care and social routines. He also experienced suicidal thoughts that increased his risk in the community. The CPN highlights that he has a dependency problem where he relies upon professionals for support and as a consequence finds it difficult to make independent choices and exert control over his life. There is also a relationship between this dependence, continuity of services and potential risk as the service user is more likely to threaten to harm himself if services are withdrawn. Risks associated with this relate to him taking overdoses. In addition, his self harm is also related to helping with emotional regulation (CPN1, Interview 1, Service User Needs, Reference11):-

"But he doesn't cope well with stress and he immediately thinks of self harm by tablets."

In this description the CPN highlights the role of stress and the resultant coping strategy of taking an overdose. Despite this relationship which is highlighted often by the CPN there is no attempt to provide the service user with an alternative strategy of regulating his emotions and helping to tolerate emotional distress.

The reason that he has re-presented to the team is that he is finding it increasingly difficult to cope with his neighbours upstairs and he is currently waiting

to be re-housed again, as the problems are elegantly captured by the CPN (CPN 1, Interview 1, CPN Interventions, Reference 3):-

“..he had neighbours who were abusive to each other. There were fights upstairs, I remember, and there was blood and stuff flying about upstairs so he couldn’t cope with that because he was disturbed with it. So I’ve gone through the process of helping him navigate a move to another property through the complaints procedure through Your Choice Homes. So he is currently on the waiting list to be moved again.

The use of evocative language ie blood flying about elevates the status of the presenting problem and helps to evoke empathy for the service user’s experience and clearly links the emerging problem with key interventions for the service user to be re-housed.

The Self Harming Service User with BPD

CPN 2 is working with a male service user in his late 30’s who is separated from his wife and has 3 children. His initial presentation was related to risk and neatly summarised by the CPN (CPN2, Interview 1, Service User Needs Reference 1):-

“There are issues about eating which we are in the early stages kind of starting to look at and I guess the main thing is his presentation has been one of mood disturbance in particular but also the startling thing about this guy is his level of self-harm, his level of risk. This is a guy who has a history of cutting himself but he’s cutting himself everywhere, all over his body so it’s not just his wrists and arms, this guy is actually covered in cuts, everywhere that you cannot see there’s just about cuts all over the place and yes that’s one of the challenges, just trying to manage that risk.”

The CPN’s use of sensational language ie cuts all over the place, amplifies the extent of the self harm and of the resultant risk which needs to be managed by the CPN, which is not without it’s difficulties. The service user also has co-existing mood disturbance which appears to increase his self harm. He is initially constructed as a very high risk individual. The next excerpt conveys the nature of BPD as being on the

boundary between neurosis (as described above) and psychosis which follows (CPN2, Interview 1, Service User Needs Reference 3):-

“He’s getting a small dose of Olanzapine, I think it’s 5mg off the top of my head. It’s just a small dose just to settle him, help with sleep and there was, one of the things I haven’t mentioned, there was some slight psychotic symptoms breaking through but nothing to say there was a psychosis or anything like that – just a little bit of stuff kind of breaking through So it was to try and settle that back a bit, you know, to try to get his sleep settled a bit

This account perhaps illustrates the challenge of understanding the nature of BPD, in that they can experience both psychotic and emotional phenomenon together but this dialectic however is not articulated above instead the psychotic element is acknowledged and minimised and the treatment of an antipsychotic medication is re-explained in terms of the outcome of the service user to help with his sleep. The concept of psychosis is portrayed as an omnipotent force with the service user powerless to help cope with the experience resulting in medication to help ameliorate the symptoms. The final excerpt enables the CPN to categorise additional problem areas together with an explanation about the overall presentation of the service user which links to his understanding of the presentation CPN2, Interview 1, Service User Needs Reference 2):-

“I think another part of it is a guy with low self esteem and a low opinion of himself and I think a part of it is about his experiences of pain in the past, possibly, I’ll stick my neck out and say, he hasn’t said it but he’s said as much, because there is probably a sexual abuse or sexual assault sitting in the background somewhere as well which has a bearing on this guy.”

In this construction the CPN identifies a framework for understanding the presentation. This is achieved with respect on ongoing risk severity; emotional and psychological reactions; symptoms of mental illness and an attribution of causality is also provided. The CPN’s explanation of the service user’s presentation is that there is probably a previous (historical) traumatic event which has resulted in the service user

developing a low opinion of himself which have contributed to his low mood. Environmental factors also contributing to this relate to his recent separation from his wife. These factors have resulted in increasing feelings which he finds difficult to cope with and uses cutting as a method of regulating his feelings. He is also unable to sleep and together with other factors described have resulted in some psychotic features.

When the three excerpts are viewed together a construction begins to emerge of someone with a high degree of self harm and resultant risk, this may be understood with reference to the CPN's use of the word "startling" which appears to indicate that there is a dramatic amount of self harm and risk evident within the presentation. This is confirmed by the CPN's account of the history and location and amount of cuts on his body. The CPN's expressed concerns about the service user's mood, eating and sleep together with the development of psychotic symptoms would tend to suggest all is not well with the service user. The CPN's attribution of these events to a possible sexual abuse or trauma provides the CPN with an explanatory framework in which to try and make sense of the service user and resultant interventions. This will be explored further as the analysis develops.

The Overwhelmed Service User with BPD

CPN 3 is working with woman with a small child, and was admitted to a mental health unit following a serious suicide attempt where she ended up in an Intensive Care Unit (CPN 3, Interview 1, Service User Needs Reference 1):-

This is somebody that was highly functioning, and who's got a full-time career and a family, that wanted to end her life quite drastically and had made several attempts including one time in ITU and she just could not function again after that.

The account demonstrates the impulsive nature of BPD where the CPN offers the opinion that she had a lot of positive things going for her and despite this had made several suicide attempts the effect of which reduced her ability to fully function both at home and at work. The CPN offers an example of the initial presentation Unit (CPN 3, Interview 1, Service User Needs Reference 2):-

Initially it was more like childlike behaviour considering that, you know, her profession is nursing, she came across very childlike and being in hospital it was like she relinquished all her responsibilities and was able to be someone that she wasn't and it has been difficult for her, and myself, to kind of readjust her back to taking back some of these responsibilities without increasing risk because the risk factors are huge, you know.

In this account the CPN appears to imply a judgement for the service user's behaviour which is constructed as childlike, the judgement is linked to the surprise of the CPN that the service user who is a nurse, is a professional and deemed competent, and perhaps shouldn't react like that. An alternative explanation for the service user may be found with respect to the therapy model of transactional analysis (Berne 1964). In this model, there are said to be three ego states which individuals can experience at any given time: parent adult and child. In the parent state the individual comes across as either nurturing or critical that is either assuming responsibility for or rebuking an individual for their behaviour. The child state will respond to this by assuming the role of helpless child or rebellious child thus matching the parent state of the other in the relationship. The adult state appears as rational and problem solving and is attempted as a way of subverting either of the two parent/ child states. Using this model the service user's childlike behaviour can be understood as one in which she is attempting to have the hospital staff act as a nurturing parent. The CPN's intervention of attempting to enable the service user to assume responsibility is similar to the adult ego states and acts to reduce the "game" that is in play between the service user and staff. There is also the inference that the service user was providing a façade into her

behaviour which she was unable to maintain. The implication is that because of her suicide attempts she is unable to fulfil her roles domestically and professionally.

This contradiction is further evidenced in her relationships with others (CPN 3, Interview 1, Service User Needs Reference7):-

“part of her thoughts was low self-esteem, you know, no confidence, although she appears to be confident she actually isn’t”

The impact of her current problems on her social and occupational roles are succinctly summarised by the CPN Unit (CPN 3, Interview 1, Service User Needs Reference 5):-

“And then you’ve got things like her job, OK who’s going to contact your ward manager?, who’s going to contact Occupational Health?, have you got a sick note?, where are you going to get that from? so that’s encapsulating that. Then it’s about the DVLA, her licence was taken off her, so what can we do? Who’s going to do it? when can you get the forms? And where’s the car going to be? So at any point in time if I ring I know exactly where that vehicle is. Then there’s an issue of child protection and very detailed who would do what, children’s social services have been in so, you know, they negotiate an assignment between me and Sarah to have a period of unsupervised access with the children to see how that went and to be reviewed in four weeks and it’s something for Sarah to look forward to but we as professionals know where we are in terms of review, so that kind of goes there. Then you’ve got one for accommodation, then we’ve got one for family dynamics and then we’ve got one for her ex-husband. She had all these things churning around; it needed to be kept in mind”.

The account contains a sense of being overwhelmed by the presenting problems in all areas of her life together with increasing risk. The discourse of the CPN appears to support the power of the professionals involved in her care. There appears to be an emphasis on the role of the professionals as all knowing and potentially powerful. This may be further explained with professional power to determine in the words of the CPN the whereabouts of her car and the authorisation via professional opinion to the driving license authorities when the service user is competent to reassume driving responsibilities. The role of CPN is concerned with safety , protection and there is also a surveillance role contained within the account. This can be understood with

respect to the Foucauldian concept of the Panopticon (Foucault 1991). The Panopticon was a new type of prison that was characterised by a central tower that enabled the authorities to observe all prisoners in their cells. This created a power relation and any deviation from the accepted ways of behaving led to a period of corrective training. This resulted in prisoners regulating their own behaviours so that violent confrontations or the need for chains became unnecessary. Foucault claimed that psychiatric power is a form of Panopticism, whereby the individual patient is monitored by psychiatric professionals where any deviation from agreed standards will result in corrective measures from psychiatry. In this case this is implied by the emphasis on monitoring the service user in terms of her safety for driving and fitness to be a parent. The experience of psychiatric care may also be viewed as a form of “corrective training” which will result in her being able to access her children and having her driving license returned. The CPN demonstrates that she has much power in the relationship and can influence legislative authorities around the issues of driving; employment, professional regulation, housing and child protection.

Her current coping strategy is described next Unit (CPN 3, Interview 1, Service User Needs Reference 6):-

She is somebody that was quite a closed book and that was using alcohol as kind of a coping strategy. She was given an alcohol dependency diagnosis but I just felt that it wasn't a dependency, it seemed to be that she was having a really bad day and then would have one glass of wine that would go to a second, she's not somebody that would crave it, because when things were going well it didn't bother her because of the driving which is why we wanted the driving licence back because it's another incentive for her not to drink you see so it all does fall into place, you know.

In this account the CPN provides an explanation for the excessive drinking and also differentiates the pathology of drinking from the service user's experience and use of alcohol and a coping strategy. There is also an air of optimism within the account with

the motivator of the service user receiving her driving license as a further incentive to reduce her alcohol consumption.

8.4 CPN Understanding of Service User Presentation

The categories related to understanding of BPD were collected during the first round of interviews which reflecting upon the diagnosis itself and also on the service users who were currently working with the CPNs. These categories also emerged whilst exploring other aspects of the interview schedule and were explored across the responses of the three CPN's interviewed.

CPN Construction of Presentation

CPN understanding of BPD incorporates multiple perspectives. The disorder is firstly understood from the developmental perspective where a theory is posited that the traits associated with the disorder are long standing in nature as the following quote illustrates (CPN1, Interview1, Understanding BPD,Reference15):-

“Borderline personality can be quite intractable and can last for years and years. People can get over it but I think it’s generally in the wool, you know, it’s ingrained in people’s characteristics and they cope, you know, some people can have a minor borderline with traits as they call it, personality traits.

This account also illustrates the rigidity associated with the disorder and how difficult it is to change or modify these characteristics. The definition appears to infer hereditary features, with tendency to chronicity and impervious to change. Another important aspect highlighted in this text is that despite the intransigence associated with the disorder, the service user with BPD is able to cope and that some presentations are classified in terms of severity that is evident by inclusion of the “minor” within the text. Classifications exist within the data where the disorder is viewed by one as on a continuum with other types of personality disorder which are

characterised by their relationship with the CPN's (CPN1, Interview1, Understanding BPD,Reference14):-

“with borderline personality, you get them very hostile, prickly, especially the other breeds of personality disorders when I say breed then I mean, they're all on a spectrum in my view which is probably right in that you have narcissistic antisocial types, they're not easy to work with.

These are further classified into whether someone is high functioning or low and this is evaluated in terms of their relative autonomy or dependence upon the CPN. This theme is further taken up by CPN 1 who relates the role of intervention is to help the service user in terms of skills deficits or deficiencies in other aspects of their personality (CPN1, Interview1, Understanding BPD,Reference16):-

“But with people with borderline personality, they function fairly well in many areas of their lives, it's the other bits you have to try and fill in the gaps and look at shining back on them this is an inappropriate way to deal with that, you know, and asking them why they view it as appropriate.

In this account the CPN is able to compartmentalise areas of functioning and implies that the service user views their own experience and estimation of functioning through a distorted lens of dysfunctional coping. Here the CPN's approach is to broaden the lens to enable him to see aspects of coping or to develop deficit areas to helps the service user function more effectively. These deficit areas of functioning are categorised by the CPNs around the areas of emotional regulation. This is underlined by a carefully constructed explanation of the complex nature of how the service user attempts to cope with these painful and difficult feelings the account is linked to self harm behaviour of cutting himself as a way of regulating those feelings (CPN 2, Interview1, Understanding BPD,Reference3):-

“Because he has difficulty in regulating his feelings and because there are major problems in dealing with, expressing, talking about feelings. There is a degree of passive anger with Stan, so underneath the surface I think he’s kind of boiling about things and there are other feelings there and how he deals with them regulates those feelings so though he manages to regulate those feelings there is no process he seems to have to be able to talk about, to express, to manage, to deal with feelings”

The explanation also links to the service user’s difficulty in verbalising his feelings and the distress experienced and how on the surface he may appear fine but the metaphor of temperature is used by the CPN to illustrate how the service user’s internal state is changing and how he is able to disguise this from the CPN in his interactions. Inferred within this classification is the dynamic nature of the service user’s presentation which can suddenly increase in intensity. There is also an incongruity in the account in that the service user is perceived to have difficulty with emotional regulation but also appears to regulate his feelings in some way. When the experience “boils over.” the service user resorts to self harm, as a tried and tested method to manage his feelings (CPN2, Interview1, Risks, Reference 2):-

“This is a guy who has a history of cutting himself but he’s cutting himself everywhere, all over his body so it’s not just his wrists and arms, this guy is actually covered in cuts, everywhere that you cannot see there’s just about cuts all over the place and yes that’s one of the challenges, just trying to manage that risk.”

The above account uses colourful language to emphasise the degree of self harm that the service user presents with and how this overshadows other aspects of his problems and needs. There is also some incongruity in the account in that the cuts are everywhere even in places that cannot be seen. There are cuts everywhere and almost all over his body as well. The emotion experienced by the service user appears present in this account of the CPN where the degree of self harm is linked to the degree of service user risk and resultant challenges that this poses so that his account is all encompassing but also less than certain.

The CPN offers initial gut feelings as to the cause of the presentation which is no more than a hunch in the early stages of engagement with the service user (CPN 2, Interview1, Understanding BPD, Reference1):-

“I think another part of it is a guy with low self esteem and a low opinion of himself and I think a part of it is about his experiences of pain in the past, possibly, I’ll stick my neck out and say, he hasn’t said it but he’s said as much, because there is probably a sexual abuse or sexual assault sitting in the background somewhere as well which has a bearing on this guy.”

This quote exemplifies an interesting paradox in that what is not said confirms what is intended to be said in terms of locating some of the causes of the initial presentation of low self esteem. The CPN then offers a further explanation about the reason of self harm which links the service users behaviour with the earlier problem of not being able to regulate emotions by inferring that some traumatic event may be the cause of the problems (CPN 2, Interview1, Understanding BPD, Reference 4):-

“There is some trauma which has a bearing on it, definitely. We’ve clearly said it’s there but let’s not look at it because the feelings are too overwhelming and it seems almost that some earlier therapy or treatment that he had, I think it was at the beginning of last year when he went to a service to have some treatment and I have actually uncovered it without putting it back again so I’ve lifted the surface off it, got him talking about it and he wasn’t really ready to deal with it.”

In this explanation the CPN attributes trauma and the difficulty that the service user has in experiencing emotions associated with it. He also links to previous therapy and that the service user dropped out of this as a clear signal that the material is too difficult for the service user to acknowledge. The metaphor of “ being under the surface” is used to underline perhaps that the service user wants to bury his previous experience but he is unable to do so as the root of the problem is exposed by the CPN and other professionals. Underpinning this is the belief that talking and exploring the trauma (as the root cause of the service users problems) will lead to relief and

acceptance of his previous experience. It is however uncertain from the account how this was negotiated with the service user and again highlights the deficits that the service user has in developing resilience over his emotions. This uncertainty over the focus of the interventions may be therefore linked to understanding of the construct of BPD, and is again underlined by CPN 2 as to the costs and benefits on focussing on exploring the root cause of emotional distress (CPN 2, Interview1, Understanding BPD, Reference8):-

“I mean there is this stuff about the past. I’m in two minds about the advantages and disadvantages of actually going there and uncovering that, feeling that that’s part of recovery and what I’ve seen working with people in the past I’mit has its pros and cons. Sometimes you lift the scab off the wound and you can’t get the scab back on.”

There is the implication of the difficulties associated with experiencing emotions and the model of working is to enable the safe exploration of feelings which the CPN is articulating that the service user is not yet ready to do this. However it may be interpreted that the CPN is ambivalent about the best way to intervene to support the service user. Building upon the previous discussion there is a tension between exploring the perceived cause if the emotional distress referenced to the “stuff” in the past. The CPN appears to be apprehensive about exploring past issues in case he is unable to help the service user resolve his feelings. Perhaps by selecting this possible course of action would enable the “scab” to heal. Perhaps the CPN’s reluctance to explore this is related to degree of risk presented by the service user and his preference for self harm possibly to help him cope with his memories. Does the CPN believe that by further explore the source of the trauma that he will further destabilise the service user? It may also be that the CPN does not feel that he has the necessary skills to enable the service user to get the scab back in place. It is as though the service user is unable to handle difficult feelings and that the CPN comes up against

repeatedly. This quote describes the CPN's ambivalence with regard to this exploration with the concept of recovery very much akin to its usage by the alcoholic who needs to confront and acknowledge their current (drinking) behaviour and therefore accept responsibility for their behaviour before being able to change it. This aspect of responsibility is apparent within the quote where the CPN feels the responsibility of attempting to reduce the service user's distress by the need to seal over any emotions associated with exploration of past events. This is also evident in the CPN's understanding of the service user dropping out of therapy being attributed to the service user rejecting the CPN due an appointment change (CPN 2, Interview1, Understanding BPD, Reference 12):-

“I obviously just interpreted it as did he see it as rejection? you know, that was one possibility that I just needed to alter the appointment, because we'd got ourselves into a routine where we were seeing each other weekly then we seemed to lose it.”

From this account the CPN had to alter the appointment from Thursday to a Friday as he was unable to make the original appointment. They appeared to be engaging well and whilst it may be the case that the service user interprets this as rejection, the CPN is able to reflect on other possible (service user factors) which may explain the beginning of disengagement (CPN 2, Interview1, Understanding BPD, Reference 13):-

“But then the other side of the evidence would suggest that he's actually possibly improved, he's back into a relationship and he's living with this guy possibly over in Gateshead, this is what I can gather anyway, and that may be a factor in it as well, so it may be that he's reached in, taken something and moved on, possibly, but, you know, my style is not really to let it rest there and I will have to check it up and persist with him.”

The service user is in a current relationship with another man and from the CPN's knowledge of the service user; his mental state has improved to enable him to return to this relationship. The account attempts an explanation into what the service user

has taken from the therapeutic encounter and the use of the terms “reached in” and “taken something” may also infer that the service user has obtained some degree of support from the CPN. It may also reveal that the service user’s distress has reduced as he has been able to “move on” from his initial presentation. The accounts appear to be forms of social action and would also suggest that the service user has re-prioritised the importance of the CPN’s intervention and is involved instead with his relationship with his partner. The CPN’s determination is also apparent in that he appears to want to continue with the service user by checking that whether he still needs to be seen. This may also infer that therapeutic contact is still available should the service user need additional support. Linking the previous two accounts may suggest that the service user has difficulty in negotiating endings in his relationships characterised by his behaviour with the CPN in not attending his appointment with no additional contact which leaves the CPN with the tensions of whether the service user is feeling rejected by the CPN or rejecting of the CPN. This is understood by the CPN in terms of the service user’s need for pleasure from relationships, on the one hand and his overall ambivalence about the meaning of his relationships on the other (CPN 2, Interview1, Understanding BPD, Reference 6):-

“Stan was I think in it for what he wants to get out of it, I think he’s in them for a bit of fun really, a bit of ...something for himself I think. It was very striking about what he wants out of them. I think another thing is I’m not sure what he wants out of them, you know.”

The quote illustrates the service user’s view of relationships and the fulfilment of pleasure as being his main goal. This would appear to imply the difficulty with deeper emotional commitment in his relationships and carries on from the previous theme of handling (emotional) difficulties that may occur in his relationships. There is a sense of fun over commitment where the latter implies

achieving deeper levels of trust, maturity, and empathy with partners which the service user is unable to experience. This may also explain the disengagement with the CPN where the relationship may have been entering a longer term phase in that the initial assessment and trust was undertaken a bit like flirtation in a relationship before committing to a relationship or committing to the long term work associated with the CPN contact.

This intensity of relationships with others was also cited by CPN (3) as a causative factor in overdosing behaviour by a female service user that she was working with (CPN 3, Interview1, Understanding BPD, Reference 8):-

“You know, and when we look back, the last overdose was after an argument with her partner and the previous one was because the marriage had broken up. So it’s more to do with the emotional side of relationships with men than it has with anything other than that. So that’s where we are at the minute, exploring that part, so hopefully she will be able to understand her life events a bit better.

The service user with a diagnosis of BPD in this account uses overdoses after conflict in her relationships occur and this is specifically located to her relationships with men. It is however unclear how the CPN has arrived at this formulation given the account of the service user’s early experience in relationships (CPN 3, Interview1, Understanding BPD, Reference 6):-

“Yes, I mean Sarah is somebody that just couldn’t cope any longer and it all stems back from, you know, a difficult childhood and boundaries with parents and it seemed like she ended up just functioning, functioning, functioning and when she was hitting crisis it would be going back to the family, she’d drink loads, probably not take an overdose at the time, got with her husband, that he was the buffer to it all and then now all that has kind of fallen apart she is back to this kind of, I’m not quite sure, because she lacked confidence when she was younger, so we talked a lot about that, about relationships with Mum and how Mum perceives her and her perception and we did a lot of that work and what it then draws out is that she actually had really low self-esteem.”

This account appears to reveal the location of the problem is initially with the parents though the father is absent from the account with the dominant discourse being between the service user and her mother and that this relationship inferred as the cause of the low self esteem. The CPN further highlights that men had a positive impact on how she coped by acting as a mediator of her emotional experience as a protective factor. The service user appears to have a one sided and self centred view of relationships like Stan which results in driving the partners from the relationship. However that he is no longer around results in the service user seeking alternative “buffers” by looking for support from her parents, which further intensified her difficulties (CPN 3, Interview1, Understanding BPD, Reference 9):-

“And feeling that there is no way out, you know. There are issues with mother, there are issues with dad, and there are issues with sister, issues with ex-partner in terms of access. She was just going to work, coming in, no-one for support, you know, and yet the work that she’s done on the ward is beyond a nurse’s role, you know, she was the one who came up with these care pathways and interventions on the ward she worked on.

The paradox of autonomy and dependency is illustrated in the above account whereby the service user is outwardly able to function at her work as a nurse and the CPN underlines the service user’s role in terms of service improvement. Being able to function amid a range of crises in her life in terms of her relationships with others demonstrates the social constructionist approach in that some aspects of her behaviour are permissible at work and those which are permissible in her more intimate domestic relationships. It is perhaps these dialectical tensions (Linehan 1993) that readily appear in BPD that helps to explain this ability to decompensate illustrated above, and can manifest itself during therapeutic engagement with BPD, for example when the service user was on the verge of being admitted to hospital (CPN 3, Interview1, Understanding BPD, Reference 9):-

“She doesn’t want services involved, you know, it’s either we do everything for her or do nothing at all and leave her alone. So we looked very much on the crisis plan and also about this “what are you going to do?” you know, “I’m not going to let you go home and take a whole load of tablets and then expect me to sit back and do nothing, that’s not how we work.”

In this account there are clear tensions between the service user’s difficulty in accepting help and the CPN’s concerns of the continuing risk factors associated with the service user possibly being at risk of further overdoses. The CPN’s understanding of the role of responsibility and the service user abdication of that responsibility is used in the above account to explain the reason for the current impasse and the CPN appears to attempt to overcome this by restating the boundaries associated with her relationship, highlighting the CPN’s responsibility for the wellbeing of the service user. The question in the discourse “what are you going to do” suggest that the CPN is attempting to either identify the risk to the service user in taking the tablets, or more likely through the use of a contingency plan attempt to empower the service user to undertake some strategies to reduce the likelihood of overdose. The role of responsibility therefore appears to link the above two accounts to explain service user expectations of others in her relationships and toxic nature of this in terms of her own autonomy and perceived capability. This is further highlighted by CPN 1 who explores in this account this understanding of the dependency needs of his service user (CPN 1, Interview1, Understanding BPD, Reference 10) :-

“It’s all about bringing you in through, that behaviour, it’s all about you know, showing you how needy and how much help you give them and they need that, but it’s just another way of communicating which is poorly understood from their point but you understand it. As a professional you’re supposed to”.

The CPN attempts to understand what the behaviour represents in terms of what the service user is attempting to communicate and further explicates this in terms of the

service user's developmental history and the expectations placed upon the CPN (CPN

1, Interview 1, Understanding BPD, Reference 9):-

“They’ll see you as the care giver, as the professional, as the person who can come and solve their problems. You’re the father I didn’t have or the brother I didn’t have and they tend to use that relationship effectively in that way, but you have to stand back and reflect back on that with them and say well, you’re an adult, I’m helping you to make adult choices and I’m not going to be here forever,”

The above account again highlights the central role of attempting to provide the service user with responsibility to enable him to function with autonomy. The difference in responsibility expectations between the service user and CPN is apparent in this account as is the manner in which the CPN attempts to manage this dynamic within the therapeutic relationship. The CPN's account of the service user's attribution of the CPN as the care giver, and the reference to the “father” or “brother” may indicate a sense of the idealisation of the CPN by the service user. This may be understood in terms of psychodynamic theory and the concept of transference, where a strong feeling is transferred from one person to another (Evans 2009). In this case the strong positive associations that the CPN experiences from the patient. However during an analysis of the attributions of caring for people Holden (1991) - drawing on the work of Menzies Lyth (1959) who wrote extensively on the manifestation of anxiety within nurses – infers that nurses have dependency needs themselves and this need can become conflicted when caring for service users who are the recipients of this care. This often results in a conflict for the nurse who becomes envious of the care that he/she is giving to the service user, and can interfere with their caring role with service users. The account may also explain the tensions between the closeness in relationship and the CPN's adoption of adult stance to help reduce the dependence in the relationship. In transactional analysis terms the service user and CPN could be said to be in a child and nurturing parent game which fosters dependency. The

service user expectation of this adult perspective may be interpreted as him being faced with the reality of the relationship and CPN's expectation to end contact eventually, together with the attributions of responsibility would suggest that there is therefore the risk of increased tensions in the therapeutic engagement process and this will now be explored in more detail.

CPN Role and Focus

Having highlighted the role of responsibility in understanding the presentation of service users with BPD it can be seen from the interviews that this concept further underpins the role and focus of the CPN (2) during the early engagement phase of the therapeutic encounter (CPN 2, Interview1, Care Goals, Reference 4):-

“I guess my goal was about the self management and the harm minimisation around his self harm, so what I went out to do was to do the work around that so that was my first aim – well my first aim was engagement, you know, engagement and to build up a relationship to build up a picture up, but the work I started with him was around kind of looking at managing self harm as well as looking at the issues of some of the problems that were the issues for him...”

In this account the CPN simultaneously works on building engagement with the service user whilst advocating and emphasising to the service user the importance of self management within the context of exploring the range of personal issues which contributed to his self harming behaviour. This may be related to the earlier construction of risk and the goal is prioritised in terms of ongoing risk with the emphasis on service user managing self and therefore assuming responsibility for self. This may underline a further tension in the initial selection of the CPN's focus for intervention. From his account the initial plan was to build engagement but somehow this was shifted to actually focussing upon the self harm. Was this shift in focus related to the underlying anxiety expressed by the CPN to the degree of risk presented by the service user expressed in the previous reference (CPN 2 Interview 1, Risks,

Reference 2). The shift in focus may help to reduce possible anxiety within the CPN. Another explanation may be found with respect to the work of Linehan et al (2006) who offer a treatment manual for working with service users with BPD and advocate that the initial targets of intervention should relate to suicidal and risky behaviours. The CPN appears to further link this in his next account to underline the initial key interventions undertaken which resemble a problem solving approach to further assist in this self management process (CPN 2, Interview1, Understanding BPD, Reference 11):-

I think looking at how he perceived his deliberate self harm because he perceived it as a negative thing and not a reframing.....seeing it as a coping strategy and his way of doing that I think and giving itI actually took along a number of leaflets about self harm and some written material and so on and you know thinking about other ways of you know coping, even like the corny stuff about putting your hand in a bucket of ice and things like that, seemed to you know...

In this account the initial attribution of the self harm is categorised by the CPN as “deliberate” which would appear to infer a degree of control by the service user. This term may have been selected by the CPN as part of the professional discourse associated with service users who self harm. However self harm can be undertaken by people who may be in a dissociative or trance like state associated with re-experiencing of sexual trauma (NICE 2004) and therefore the term of self harm is preferred with the prefix of “Deliberate” often associated as a pejorative term by service users which can increase stigma (Jeffery 1979). Notwithstanding this, the CPN’s frame of understanding is related to the earlier concept of self management and by use of educational materials he attempts to help the service user find alternative approaches to coping which are less harmful. Thus in this example early engagement with the service user is achieved by the focus on the problem presentation, the selection of treatment goals and the early use of psycho education

emphasising the service user's role in taking responsibility and managing his distress by alternative and less harmful means.

In contrast to the self management model advocated by CPN2, CPN1's initial focus was a more pragmatic one and related to the practicalities of the service user's domestic living arrangements. Having related that the service user's distress was a result of difficulties with his neighbours in that they were always fighting the initial focus of re housing is selected by the CPN and service user (CPN1, Interview 1, CPN Interventions, Reference 3):-.

So I've gone through the process of helping him navigate a move to another property through the complaints procedure through Your Choice Homes. So he is currently on the waiting list to be moved again. He lives in Heaton now, he lived in Walker before that and he had neighbours who were abusive to each other. There were fights upstairs, I remember, and there was blood and stuff flying about upstairs so he couldn't cope with that because he was disturbed with it. They were beating each other up. I got him moved to Heaton.

In this account the CPN who knows the service user well, selects the re-housing intervention which he utilised before to enable a move to his current home as he was having difficulty coping with previous neighbours. The service user has a recurring problem in coping with distress associated with other people and a practical solution is undertaken. The nature of the discourse with the CPN getting him moved would suggest that the issue of responsibility has been transferred from the service user to the CPN with the service user assuming a more subjugated role in the relationship. However the importance of working to the service user's agenda is also highlighted by CPN1's account of responding to his service user in crisis (CPN1, Interview 1, CPN Role, Reference 12):-

"If you put in a hierarchy of what's important to him and how we can respond in crisis you can always give him a little guide map and if you don't feel well or unhappy you try to point him to appropriate methods to cope with those things. See if you give him like a menu, a buffet, this is what you can do when I'm not here ".

In this account the CPN helps the service user to adopt a problem solving approach to promote alternative coping methods to his crisis and also is an approach to work towards self management and reduce his interpersonal dependence upon the CPN.

8.5 Engaging BPD

Engaging the Self Harming Service User with BPD

At the outset of the engagement process the approach undertaken is of a low key and informal basis aimed at getting to know the service user whilst allowing the service user to identify his own needs and not direct him in any particular area (CPN 2, Interview 1, Engaging BPD, Reference 3):-

“I think Igoing out to his house, sitting down having a cup of tea with him, talking about what he wanted to address and the issues that he wanted to talk about and not kind of leaping ahead on to the agenda of well,

The initial focus is on letting the service user take a lead in deciding on the session direction and prioritisation of needs. This is achieved in the naturalistic setting of the service user’s home and reinforcing normality in terms of having a cup of tea. This would suggest a more informal feel to the engagement process with a sedate and slow pace to it as well. However the CPN has a dual focus of building the relationship and also in understanding the service user’s needs and goals. This is achieved in terms of the immediate risk, for example the presentation of self harm (CPN 2, Interview 1, Engaging BPD, Reference 1):-

“But that’s what we seemed to start to focus was the here and now, was, you know, “What’s happening with this?” “How do I kind of manage this?” and that’s where we kind of started out really, it was doing just some work about managing self harm and talking about why self harm and that kind of thing which”

In this extract the CPN undertakes more control and direction over the relationship and begins to look for patterns and antecedents to try and enable both him and the worker to better understand the context of the self harm. The early relationship can be

viewed on a continuum of informal social interaction to structured and planned interventions from the CPN as the following extract show (CPN 2, Interview 1, Engaging BPD, Reference 2):-

“we were looking at triggers, we were looking at some of that stuff and we were looking at his homosexual relationships and how they were having a bearing on him and they were leading to, I guess in a sense starting to do the early work of a formulation, starting to build a picture up, you know, what the triggers are, starting to look at some of the beliefs behindprobably starting to create the kind of CBT kind of formulation.”

In this example the CPN develops a more directive and specific focus to piece together the information obtained for the service user and uses the frame of cognitive behaviour therapy to facilitate this process. This enables some collaborative work to take place resulting in positive feelings for the CPN when engaged with the service user (CPN2, Interview1, Emotional Reactions to Service User, Reference 7):-

“it was lovely actually because it was almost like it was quite enlightening. You know, it was like a light bulb went on and he was able to connect feelings with self harm, see why he felt better with self harm and start to think about other methods but also what he wanted to do was stop self harming and there was a commitment to that and certainly up until the period when I last saw him,”

Despite the socially constructed views of BPD as being difficult and manipulative and attention seeking, the service user and CPN are actively engaged in attempting to stop self harming behaviour and deeper levels of empathy are demonstrated resulting in the CPN developing reflexive thinking from the service user. There are positive feelings evident in the CPN’s account and that BPD service users are able to collaborate within the session and integrate some learning from the collaboration in the therapeutic relationship.

Disengagement

The CPN in working with the service user with current self harm and having related that engagement was going extremely well, with him and the service user

focussing on self harm, suddenly experiences a lull in therapeutic contact (CPN 2, Interview 1, Disengagement, Reference 2):-

“I thought we’d hit it off, you know, I thought we had, we’d got going with a few sessions and, you know, I needed to just change the appointment from one day to another from a Thursday to a Friday because I couldn’t make it and we just seem to have lost it since then.

The CPN recounts that changing the service user’s appointment may be a cause of the non attendance. The agency for the behaviour is clearly located within the CPN and the discourse represents an imbalance in power relations favouring the CPN as there is no communication and negotiation with the service user over possible new dates and may account for the non attendance. This is further constructed below (CPN 2, Interview 1, Disengagement, Reference 3) :-

“I obviously just interpreted it as did he see it as rejection? you know, that was one possibility that I just needed to alter the appointment because we’d got ourselves into a routine where we were seeing each other weekly then we seemed to lose it.

However further exploration reveals some additional information which may cast some dispute over the previous argument regarding agency (CPN 2, Interview 1, Disengagement, Reference 4) :-

“But then the other side of the evidence would suggest that he’s actually possibly improved, he’s back into a relationship and he’s living with this guy possibly over in Gateshead, this is what I can gather anyway, and that may be a factor in it as well, so it may be that he’s reached in, taken something and moved on, possibly, but, you know, my style is not really to let it rest there and I will have to check it up and persist with him.

These two excerpts reveal the tensions within the discourse of responsibility, initially attributing this to the CPN for the appointment change and how the service user may interpret this and secondly by the patient in deciding to leave therapy as he resumes his relationship with his previous partner and therefore becomes rejecting of the therapist.

Handling difficulties within the relationship and particularly non attendance is highlighted within the next excerpt where the service user has not responded to telephone calls and a letter. The issue of discharging the service user is raised in the conversation (CPN 2, Interview 1, Disengagement, Reference 6):-

“Probably not straight away but obviously discharge might be down the line, you know. I think we’ve got to bear in mind that there are risks around this guy and the fact is he’s obviously connected with out-patients as well so I can’t just sit here and say, “Right you’re discharged,” The risk element worries me, as he does all of us. He’s kind of a risky guy.

The conversation flips between the risks posed by the individual, the concerns raised within the CPN and the relationship with the medical consultant that he is seeing in out-patients. The main reason provided for not discharging the service user is that he is an outpatient and the primacy given to that role governs the CPN’s behaviour. This echoes the observation part of the study whereby the psychiatrists felt that they seen the most service users within the team and the default position is to hand over such service users to the medical staff. In this case the CPN is unable to withdraw despite the improbability of the service user returning to the sessions. He emphasises that this means he is unable to discharge the service user and then appears to obtain some support for the position by reflecting on the risks and concerns posed by the service user.

Engaging the Overwhelmed Service User with BPD

In contrast to the informal approach to engagement with the previous service user a key characteristic of the engagement process with this service user is the need for clear roles and responsibilities in the relationship within the context of clear and open channels of communication (CPN 3, interview 1, Engaging BPD, Reference 11):-

“Being open and honest, being realistic and right from the off is to explain the roles and responsibilities of everyone.

The open and honest approach appears to increase trust within the relationship and maintains the therapeutic relationship as the following extract demonstrates (CPN 3, interview 1, Engaging BPD, Reference 13):-

“She tells... you know, she made a point of saying to me and Dr Smith that she appreciates our honesty. “You’re not going round the houses,” I think she said, something along those lines. She just told me how it is, “I haven’t got time to mess about,” type of thing.

Within this extract there is the inference from the service user of the need to get started and not to mess about with the session. However the nature and structure of the session which feels directed and controlled by the nurse with an emphasis on formality and boundary setting would suggest that the nurse does not wish to “mess about” and quickly gets down to business with the service user. There is a directness and clarity of expression between the participants. The need for clear communication between all members of the CMHT involved in the care of this service user was felt to be important for this CPN, to enable her to further engage with the service user. This appears to be related to perhaps helping the CPN to reduce her anxiety during engagement and deal with sensitive issues by the inclusion of medical staff within the consultation (CPN 3, interview 1, Engaging BPD, Reference 4):-

“It was me, Dr Smith, with Sarah so it was a three-way conversation about, and quite interestingly, very open and transparent, so I was able to say, “Look, this is what my concerns are, you know, how can we agree for you to have your children back when you are taking overdoses?”

In the above extract the CPN appears surprised that the service user responded to the open and honest approach. Does this infer a surprise located within the service user or does it suggest that the CPN is developing her experience with this type of service user and is attempting to be reflexive about the interpersonal approach employed with the service user? The inclusion of medical staff may increase support for the CPN

during the interaction but may also serve as potentially disempowering the service user into accepting the proposition being put forward by the CPN. There is the construction of self harm with child welfare and having access to her children being dependent upon the service user accepting responsibility for reducing her self harm. Implicit within this is a degree of coercion for the service user to adapt to societal and legislative norms in order to fulfil her role of mother. Part of that role is to be able to contain feelings and regulate her feelings. However further empowerment is achieved at the outset of the engagement process by the negotiation of responsibility which the CPN correlates as an attribution factor for reduced risks (CPN 3, interview 1, Engaging BPD, Reference 3):-

“Very little and that’s because we made the decision that we would give her back the responsibility for a number of aspects of her life and she got up and she got on with it and we have had no risk behaviour at all.

The empowering / disempowering continuum is evident with the service user with the granting of permission to take on certain roles and responsibilities. This dual approach of confronting the service user and challenging with an alternative viewpoint related to the service user accepting responsibility is a key feature of engagement with this service user (CPN 3, interview 1, Engaging BPD, Reference 10):-

“I’m functioning well, and I’m doing this, why won’t you let me have the kids back, why won’t you do my letter of recommendation?”
“Well hang on a minute, I’m sorry but this overdose is not something” you know, and it was about explaining the concerns and explaining the risks so the majority of the crisis planning you’ll notice on the first part are very much about ,”What are you going to do?”

Within the discourse of the CPN in which she continues to construct self harm with child welfare and the risks to them of a self harming mother. There is the possibility that the service user is undertaking the tasks to receive her reward but the CPN withholds that reward whilst demanding more progress from the service user. There

is a clear imbalance in power and the service user needs to co-operate in order to receive the CPN's judgement that she is fit and proper mother. The CPN clearly articulates the need for service user responsibility and there is a subtle contradiction within the following extract in that responsibility is granted by the care team who have the source of agency to enable the service user to accept responsibility (CPN 3, interview 1, Engaging BPD, Reference 5):-

“but with Sarah we had to deal with a number of issues all in one go and she managed that so far, which, OK is a little bit uncomfortable and we ended up having to take a risk but we made that choice with her so,,,

This extract also highlights that empowering the service user to accept responsibility is at times fraught with risk and results in anxiety within the professionals. The concept of choice implies a choice between professional and serve user but could also be seen to be a choice to take in terms of risk taking which may have resulted in discomfort for the professionals as well as the service user. Similarly confronting service users when they experience set backs can also be uncomfortable process and the CPN demonstrates that defining the roles and responsibilities early on in the therapeutic encounter can facilitate this process (CPN 3, interview 1, Engaging BPD, Reference 12):-

“well there are, I mean our whole plan was put to you shall we say, a couple of weeks ago now, and you know, Sarah came into the appointment, looked well,well but had no idea that we would have spoken to CAT, that we'd already spoken to A and E. We knew what she'd drunk, we knew what she'd taken and I think she was taken aback by that and she was reminded about services communicating with each other and remember when I was saying you know, “I will be responsible for co-ordinating your care so that information will have come to me.” I said, “You've walked into the room,” and I said “you've categorically denied that you've done that,” and that upset her. She said, “Look I've tried really hard not to tell you,” so we explored that and it just... because we'd already put it in at the beginning it was easy for us to then approach

The above description of uncovering a set back through a direct approach appears to have facilitated and deepened the therapeutic engagement with the service user. The confrontation led to further exploration and reveals an attempt by the service user to present herself as functioning well and independent despite having presented to A& E with an overdose when drunk. There is also the tendency for splitting to occur among professionals which is characterised by dispute and argument within the team. The CPN appears alert to this possibility and prevents this with a pre-emptive strike implying that she has communicated with all extended team members to get a detailed account of the service user's progress since last session. A further example highlights how the management of disputes between the CPN and service user can lead to the development of the relationship (CPN3/Interview 1, Disputes, reference 3):-

“it was about the fact that I was able to say to Sarah, “You are somebody that I would consider risky and she wanted a FACE Risk and said you know, “This is where I want to go quite risky for someone like you, but you’ve not given me anything to say that that has changed”, and that’s when it opened up a whole different conversation, but we had to try it ,by trial and error, that’s how I learned.

The assertiveness shown by the CPN in explaining to the service user about her current risk profile and being clear to the service user of the consequences of her current risky behaviour results initially in some dispute between the service user and CPN in that there is a differences in opinion about the current way forward. The CPN by highlighting her concerns and actions results in the relationship becoming more open and subsequently opens up new areas of exploration for the service user and CPN.

Acknowledging the service user's negative feelings is also important in engaging the service user and is an important step in building trust with the service user (CPN3 / interview1, Disputes, Reference 2):-

“Going through it, seeing actually what we did actually wasn’t a positive thing and when you’re exploring it with Sarah she’ll say, “You

know I'm sick of this," or "I'm sick of that," and it's about having a discussion, being very open, where are you coming from and can we have this in writing so we all know what we're doing and what we're trying to

Here the CPN enables the service user to ventilate her negative feelings and in doing so helps her to identify what is making her "sick" and lists these as problems which they can tackle together. This collaborative approach enables the team and service user to focus on a direction for their therapeutic efforts.

The Interpersonally Dependent Service User with BPD

Engagement with the dependent service user would appear to be easier than with the previously described chaotic service users or those with more risky behaviours for example ongoing self harm. In the following excerpt the CPN describes some of the service user factors that make engagement easier (CPN 1 Interview 1, Engaging BPD/Service User Factors, reference 1):-

"they want you to listen to them and they are very demonstrative as people. But when you're working with him he's very pleasant, he's a nice chap

(CPN 1 Interview 1, Engaging BPD/Service User Factors reference 4):-

"He's always very pleased to see you and he's always very socially warm, it's not difficult to engage him. He always turns up to appointments and he will ring you if he can't make it and he's very accommodating.

This describes the service user who is isolated and has very little other relationships and contacts and is dependent upon the CPN for his main support. As such these service users always keep their appointments and rarely cancel and build up a significant reliance upon the CPN. They usually have a pleasing demeanour and do not wish to challenge or upset others in case their support is withdrawn. On the

surface they are engaging and can be more satisfying to work with as they shift responsibility onto the healthcare worker who can be the problem solver for the service user and tell them what they need to do to solve their problems. In addition the CPN makes a positive evaluation towards the service users which in turn has a positive impact upon the engagement process.

However the interpersonal dependence by the service user on his CPN results in the CPN having to switch between the roles of providing support whilst attempting to create autonomy within the service user as shown in the following extract (CPN1, Interview 1, Engaging BPD, Reference 1):-

“it almost becomes a paternal relationship sometimes because they look at you as somebody who is a positive role model for an adult and it’s a funny relationship you develop with people who’ve got a typical borderline personality.

The CPN further articulates his frame of reference when working with his service user in terms of clear roles which he feels facilitates the therapeutic relationship. There is the construction of the BPD service user as having a typology which also affects the therapeutic relationship. This may link with prior expectation and stereotypes of service user presentation in that if you expect certain experiences then you are more likely to have that experience. However there is some suggestion that the CPN is attempting to appeal to the interview by presenting himself in a positive light about how he is stimulated by the service user group, and also by comparing himself with my work setting(acute ward) by downplaying the role of staff working ie the unit whilst amplifying the role of the CPN (CPN1, Interview 1, Engaging BPD, Reference 2):-

“On a ward your main function is to run the ward safely and you get competing pressures on the ward’s time, but now you’re spending this time with me and I’m giving you time back so like in the community you go and see someone at home and you try and work problems out on a solving basis one by one and usually if you prioritise

things and keep the boundaries very stiff with that problem it works better and you know where they stand and you know where you stand but I find borderline personality very interesting

There is a further contradiction in his account of keeping the boundaries tight together with the setting of the therapeutic encounter (CPN1, Interview 1, Engaging BPD, Reference 7):-

“I meet him at a coffee shop down the road. In terms of being more contained and confidential it’s better, it’s more normal to meet him in a café.

Here the CPN states that the informal social setting of the café is more containing and confidential than a consulting room. The former is connected to social engagement and appears to be a tension with normalizing the service user and structuring therapeutic work to reduce his interpersonal dependence. It may also be that the social norms of the café enable the service user to act in a socially acceptable way commensurate with the social setting. This may also explain why service users’ display acting out behaviour within a hospital ward. However the CPN’s understanding of the service users’ distress is related to his isolation from others and lack of meaningful occupation which he is attempting to overcome by focussing upon recovery focussed interventions aimed at increasing his social participation (CPN1, Interview 1, Engaging BPD, Reference 12):-

“I aimed for discharge by February, this was a couple of years ago, and he did fairly well, he was working doing the voluntary work and so I said,” You know I’m just trying to introduce you, because you’re not connected to people, to all these places to keep you busy and instead of me being in there you replace me with another activity that’s going to keep you occupied and, you know, the old mantra, the more you do the better you feel. You know what I mean? And he did respond fairly well to that and I think through stress with the flat and the people upstairs beating each other up repeatedly and physical health problems, he went into hospital, he had quite a serious overdose, quite a dangerous overdose a few months ago where he took a large amount of

In this excerpt the CPN begins his account by telling a story of the service user's recovery during a previous encounter. The CPN reports that he is attempting to discharge the service user and provides a rationale for why increasing participation will have a positive effect on his mood, on increasing his independence. He then connects his progress with the service users current set back and the resultant stress which resulted in an overdose. The passage highlights the unstable nature of the service user's progress, the nature of the challenge and difficulty in working with the dependency and risk of self harm and the struggle associated with keeping the service user on track.

Underlining the CPN focus with the service user is the need to keep the service user safe and this is demonstrated within the next extract and this is also related to some of the underlying beliefs of the CPN (CPN1/Interview , Engaging BPD,/Service User Factors, reference 6):-

“My feelings are like, I just want him to do the right thing, you know? I want him to be safe because anything negative that happens to your patient you do feel automatically that you've failed in some way so you want to avoid that feeling so you want to do successful interventions don't you? We've all felt a failure when something bad has happened to patients and it's not pleasant so you'll fight to keep them going, you know.

The relationship between keeping the patient safe by successful interventions is related to the avoidance of negative feelings within the CPN. This is related to the beliefs of failure and appears to link negative patient outcomes with responsibility being attributed to the CPN by himself. Perhaps the discourse within this text is similar to the frame of reference described earlier by the CPN in his description of ward staff and that notions of safety and personal responsibility have been determined by the profession of nursing and organisational views of safety and aversion to risk which results in potential bad feelings for staff if service users do harm themselves.

The tension between keeping the service user safe and challenging his dependency needs has also been considered in the management of the case. The need to move the service user on and reduce the therapeutic engagement may also stir up feelings within the service user: (CPN1/Interview1/ Therapeutic Withdrawal/ Reference 1):-

“it’s hard to disengage because of the risky behaviours that they’d exhibit, you know it’s like well, “I’m going to discharge you,” and then you’ll get a call from A & E and the CAT Team saying he’s self harmed or he’s overdosed.”

In this example the CPN whilst attempting to discharge the service user has resulted in additional self harm which is a behaviour which enables the service user to seek help and thus maintains his contact with the CPN. If the CPN persists in discharge then the service user will increase his behaviours until he is seen again and taken into regular contact with the CPN. In this case there are clear links with the notion of responsibility identified earlier and also as the CPN explains is behaviour designed to “hook you in”. Although from the following extract the CPN appears to provide an alternative perspective on what is happening in the relationship during withdrawal:

(CPN1/Interview1/ Therapeutic Withdrawal/ Reference 2):-

“Well, it would probably make him feel a bit lost and a bit abandoned. He would probably feel abandoned by me but he didn’t do too badly last time because I spent months aiming at that,”

Here the CPN appears to be empathic towards the service user’s perspective and acknowledges the importance of allocating specific time to enable the service user to accept the inevitability of separation from the CPN. Perhaps an important aspect of discharging service users is spending time at the outset identifying the approximate therapeutic contact and when the end will approximately occur. By doing this the service user and CPN would be actively engaged with a therapeutic contract aimed at ending the relationship and would therefore keep this eventuality in focus throughout

contact rather than at the end of therapy with potential for higher levels of distress experienced by the service user.

8.6 Emotional Reactions to Service User

Emotional reactions experienced by CPN s' whilst working with service users with BPD relate frustration, anxiety, helplessness and also the likeability of the service user. These will now be explored in more detail.

Helplessness

CPN 3 reflects on her earlier nursing experience in working with this service user group and further explains the effect that this particular service user group can have upon the mental health nurse where there are gaps in knowledge and management of the service user (CPN 3, Interview 1, Emotional Reactions to Service User, Reference 1):-

“I would say that I’ve grown wiser within my nursing career and I suppose I’ve gained the skills and the knowledge to be able to make better judgements, but I must admit it is a disorder where I’ve found it extremely difficult to nurse somebody, because you weren’t quite sure what would be the best way to help them with that diagnosis, so I felt a bit helpless and lack of understanding.”

The above extract offers a window into the CPN’s beliefs associated with the uncertainty of working with this service user group. She endorses that she feels helpless and use of the term nurse seems to imply that she is recalling her experience of the in-patient setting and that her evaluation of herself reflects the inadequacy of the in-patient team in looking after these service users as is indeed endorsed by an earlier comment from CPN 1 of his in-patient experiences (CPN 1, Interview 1, Organisational Perspectives on BPD, Reference 8):-

“when people in the wider world of psychiatry, in the wards, might think well there’s nothing wrong with you, you’ve just got borderline personality, and that writes them off

He further offers examples of nurses' from an in-patient settings attitude towards these service users (CPN 1, Interview 1, Staff Reactions to Diagnosis, Reference 2):-

“it became more mentioned and it was used very much in a dismissive term on the ward, very much as a negative term like, “Oh no, not another borderline personality,” which automatically put people off”

In the above account the CPN explains the relationship between attitude towards BPD and the resultant lack of engagement with the service user as a consequence of how this group of staff evaluated the label of BPD. In these extracts there is clear stereotyping and negative labelling associated with this diagnostic category. There is also the relationship between the label and the social distancing which occurs in forming relationships with these service users. There is also an implied social model of the service user held by staff that the disorder is factitious or that the label is out with the dominant discourse of psychiatry which the nurses were influenced by. CPN 3 further elaborates the emotional feelings that she experienced while feeling helpless when working with the service user (CPN3, Interview 1, Emotional Reactions to Service User, Reference 2):-

“Definitely, the whole concept for many years....I’ve found it extremely difficult, frustrating, I think is the word.

Based on these previous cultural experiences of working with BPD the CPN further articulates how she was feeling when starting to work with her current service user (CPN3, Interview 1, Emotional Reactions to Service User, Reference 5):-

“Honestly? I felt, “Jesus Christ.” It’s been a difficult diagnosis to work with at the best of times so I was really apprehensive.

This account’s use of colourful language shows the intensity of emotions that can be present when working with service users with BPD. She goes on to further explain the

frustrations linking it back to the in-patient experiences and helplessness experienced (CPN3, Interview 1, Emotional Reactions to Service User, Reference 6):-

“It was about that helplessness. In the past you know I don’t think we’ve been the greatest services to offer people with the diagnosis, and then it was kind of, you know, “Is it mental health?” “Is it not that familiar and also coming from the ward where you would just section people time and time again because you didn’t know what to do – pure frustration.

The CPN acknowledges the lack of familiarity with the diagnostic categorisation of service users and questions whether it’s a mental health problem and also explains the relationship between this lack of understanding and resultant behaviour of “sectioning” people with the mental health act. This can be explained by earlier discourse relating to responsibility where the staff would appear to take responsibility away from the service user by disempowering them via the mental health act, as a method of containing their own anxiety and frustrations associated with caring for this particular service user group.

Frustration

However the following account shows how the CPN handles this frustration when working with this service user in the community setting (CPN3, Interview 1, Emotional Reactions to Service User, Reference 7):-

“When she did take the second overdose I thought, “Oh crikey, what do I do, where do I go?” and then I thought, “Actually, No, that’s the plan. And lo and behold the next day the plan was put in again. There wasn’t that frustration of starting again, it was a continuation, that was the difference.

Here the CPN initially feeling anxious and accepting that she should solve the problems for the service user thus re-enacting the helplessness actually shifts this back to the service user by looking at the previous care plan and this seems to reduce the frustration whilst working with this service user during her crisis. There is a

predictable pattern of responding to the service user from the management plan which is employed in unpredictable situations. The anxiety and reflexivity of the CPN would suggest a novelty with the approach. Reflecting on how she has grown in working with the service user group (CPN3, Interview 1, Emotional Reactions to Service User, Reference 8):-

“You’ve come to a nurse that was quite judgmental and found it very frustrating and I’ve used some very key words there, because I think that’s important to know from a research point of view. It’s not easy, you know, and to be able to shift and to work with somebody with a diagnosis like that, you need to have certain things in place.

The CPN acknowledges the need to have some structures in place when working with the service user which is not only therapeutic for the service user but also reduces tensions in the nurse as well.

Anxiety

The reduction of uncomfortable feelings is highlighted by CPN 1 as well (CPN1, Interview 1, Emotional Reactions to Service User, Reference 6):-

“I find I don’t feel as uncomfortable with the behaviours as I used to. I know a bit more about it,”

Here the CPN makes the association between knowledge and experience as a mediator of feeling uncomfortable with the service user’s difficult behaviours. This is further elaborated upon (CPN1, Interview 1, Emotional Reactions to Service User, Reference 7):-

“I used to be uncomfortable about self harm but now I understand it more, I don’t shriek when I see it and a lot of people find the acting out behaviour is really uncomfortable but, you know, when you’re in the community you’re looking at keeping your patient alive and functioning so you’ll tend to look at these behaviours as contained as far as you can and say well if that helps you, compared to the risks you are running, if that helps you and you feel better from it, that’s fine.

In this excerpt the CPN draws upon evocative language to make his point about how some nurses may respond to the service user's difficult behaviours. The use of "shriek" demonstrates a sense of the dramatic, and linked to the next phrase reveals the CPN's frame of reference regarding perhaps those acute in-patient nurses whose experience and reactions are sharply contrasted with his own experience as one who helps to contain difficult service user behaviours and help the service user to cope and regulate those feelings. There is the suggestion that the response to the service user is dependent upon the setting and the various discourses that shape each setting. This development of knowledge and its relationship to the CPN's ability to cope with the service user's risky behaviours is encapsulated in the final reflection from the CPN (CPN1, Interview 1, Emotional Reactions to Service User, Reference 11):-

"He used to make me feel very, very anxious. He used to, but maybe it's me developing as a clinician or our relationship developing that he kind of knows I'm a safe pair of hands, that's kind of chilled down now."

Within this account there is a hint that the service user is somehow testing the CPN to determine how he will be able to handle his extremes in behaviours. This appears to be related to the service user developing trust in the CPN by attempting to push the CPN away by the use of destructive behaviours and reminds me of the interplay that the service user experiences between needing a relationship and at the same time finding it difficult to sustain a relationship with the CPN.

Anxiety and tension is experienced by the CPN when his goals appear to clash with overall complexity and chaos associated with the service user's presentation (CPN 2, Interview 1, Emotional Reactions to Service User, Reference 2).

"Of course there's that tension there you know, when you're trying to deal with everything really and you really want to try and get in and do a piece of work about something and it's difficult to because there's other stuff that you're dealing with that's kind of going on and that's certainly the case with Stan."

Here the tension is related to the CPN being thwarted by the service user in attempting to intervene and move him along with a focussed intervention. This tension can increase to frustration by the service user's disengagement from the therapeutic process (CPN 2, Interview 1, Emotional Reactions to Service User, Reference 4):-

“Yes, he has and it's very frustrating. It seems to have gone off ... we were going places but then it just seemed to go, you know.

The emotional reactions then shifts to anxiety when the CPN reflects on the risks associated with the non attendance (CPN 2, Interview 1, Emotional Reactions to Service User, Reference 5):-

“Yes, there is a concern about risk, you know, there is an anxiety about risk and I again you know I haven't sorted this out in any particular order, but one of the things I didn't mention when I first started talking about risk, because predominantly the self harm is that this guy walks across bridges and other things like that and there's a suicidal element to it and then at the back of my mind you know, I felt, am I going to come in and this guy's tossed himself off a bridge?”

In this extract the CPN appears to accept responsibility for the risks associated with the service user's non engagement. His discourse is related to previously non discussed material in the form of suicidal thoughts about walking off bridges. He categorises self harm and suicide in the same sentence as though they are used interchangeably but perhaps by his last sentence he is more concerned about the suicidal nature of the service user's behaviour as though their expression is on a continuum.

Prior to the service user's non engagement it is important to recognise the positive feelings associated with the therapeutic encounter. This is highlighted within the next excerpt (CPN 2, Interview 1, Emotional Reactions to Service User, Reference 6):-

“so there’s a bit of me that’s there so there’s the kind of concern, and the worry side of it. There was a good feeling about him as well, just about how he was, certainly at the start of it, it was a very positive feeling that you got from him about how he responded to the, you know, how he got the information, how he kind of you know responded to that”

In this excerpt the discourse moves away from concern and worry to one of hope and enthusiasm. There appears to be a good therapeutic relationship in that there is good bond, and the therapeutic alliance is working on tasks associated with understanding his needs. These positive feelings extend to the CPN’s relationship with the service user’s family (CPN 2, Interview 1, Emotional Reactions to Service User, Reference 8):-

“The other thing that was striking about him was that, you know, to a degree I seemed to hit it off with his family as well, because when I got there I spoke to his mother and I spoke to his father. It was very strange, they were very open with me as well yes. They’ve got money problems. They were extremely open with me, I was a bit surprised but I seemed to hit it off with them.”

Here the CPN articulates some surprise about the relationship with the family. This could be interpreted in one of two ways. Firstly that the family would wish to engage with a member of the mental health services and offers some attribution that perhaps because of money problems they were open as a way of getting some help. However an alternative interpretation is that the CPN has some self doubts about his own presentation with the family. This is emphasised by the use of the rhetorical device “striking” as though this stands out for the CPN and is then supported with the “very strange” which is sandwiched between the use of surprise that he hit it off with them. This self doubt surface elsewhere in the conversation (CPN 2, Interview 1, Emotional Reactions to Service User, Reference 3):-

“one of the things that does strike me is this, you know, could I be a bit off putting, you know, myself? Erm. Because I have got a slightly different accent, I haven’t got the right accent, you know, and things like that you know, so what do people make of me?”

The CPN highlights the interpersonal factors within professionals which may affect the relationship. He focussed upon his own self image in terms of his accent and accepts responsibility that this may affect the therapeutic encounter with service users which would account for the non attendance. The CPN appears to be making some inferences about his own self worth and that he is open to judgement from others which may affect his confidence when working with this service user group.

Likeability of Service User

CPN 1 acknowledges the relationship between the service user's presentation and the subjective evaluation of whether the nurse likes the patient (CPN1, Interview 1, Emotional Reactions to Service User, Reference 5):

“You have to work hard to like them. In actual fact you don't actually have to like them , you have to be professional and objective about what you're doing with them but Alan's not like that, he's more of a nice fella who doesn't adapt his behaviours correctly because of his, you know, the way he's grown up.

Within this extract the CPN initially states that you need to work hard to like the patient then contradicts himself with stating the opposite in that liking the service user doesn't not come into it and that the nurse should always portray a façade of professionalism when working with the service user group. He then goes on to say that the service user he is working with is actually quite nice offering a positive evaluation of the service user which is mirrored within the positive nature of the therapeutic relationship. There would therefore in this CPN's view be an association between positive patient characteristics and the development of the therapeutic relationship? This reminds me of some work I took a few years ago examining the relationship between therapeutic alliance and patient and therapist factors and found that negative patient factors such as aggression resulted in a negative therapeutic

relationship with the service user. It may also be that the CPN is more in control of the direction of therapeutic contact and is not challenged too much by this service user who is mainly clingy in presentation and enables the CPN to be more directive and powerful in his transactions with the service user.

8.7 Recovery Focus

With regard to the concept of recovery the CPNs endorsed two main views that captured their concept of recovery: a normalising approach and non stigmatising interventions.

Normalising

The concept of recovery was felt by the CPN's to have been around their work for a number of years with one CPN remarking that it was nothing new and always a part of the job:- (CPN3/Interview1/ Recovery Focus/ Reference 1):

“I don't think recovery from a nursing point of view is something new and I don't think it's something, you know, “recovery, let's just do it”, I think that it's something that I feel that I've been doing ...irrespective of where I've been working. It's always been about, you know, howI'm very much keen on normalising people's behaviour and normalising people's lives and linking them into communities and activities that are not mental health led and supporting somebody to do that. I've never seen it as a concept. It's always there, always has been.

In this account the CPN explains that she always kept a recovery focus irrespective of settings in which she worked. She defines recovery in terms of normalisation approaches and this is characterised as supporting peoples' growth independent of the mental health system. Recovery is constructed to enable the service user to use services that are not mental health service related, to create independence from the mental health system. This is echoed by her colleague: (CPN1 /Interview 1/ Recovery Focus/ Reference 1):

“You have to, you know, do as much as you can to get things in the right place for him, make sure he's got the right level of benefit, he's got adequate housing, try to encourage him to connect with his old

friends and his family and stuff and that you've boundaried the dependency well enough and I think it's about normalising his life and getting him to generally agree that things aren't going to be perfect and we don't all have the luxury of having a care co-ordinator,

Again this CPN relates to the concept of normalisation and the importance of adequate levels of housing and income support. The account however whilst highlighting the need for normalisation, does not appear to support service user choice and growth but one of dependence upon the state and the status quo. There does not appear to be any dynamic focus for the development of movement of growth within the account.

Non Stigmatising Interventions

The concept of recovery is bound up within normalisation and with that an acceptance of the limits associated with his current dependency. This appears in contrast to the former CPN's account (CPN3/Interview1/ Recovery Focus / Reference 2):

"It's to help somebody to reach their optimum quality of life whatever that may be with whatever they need whether that is kind of support groups or, you know, if they are ethnic minorities, linking in with the right communities, knowing what's out there, signposting.....

This contrasting account of recovery emphasises optimal functioning which can be user defined and the need to link in with local groups who perhaps can provide support to service users and promote a non stigmatising intervention. This is shown in the next extract: (CPN3/Interview1/ Recovery Focus / Reference 3):-

"I would have her out of mental health services. This is somebody that, you know, five years, well, two years ago was functioning as an ITU nurse at degree level, got three kids, doing really well, great house, functioning really at a very high level and all of that has broken down so for her and me what we have negotiated is that she needs gets up to, you know, the kids, back to work and to be able to

Here the CPN makes the link that since the service user has come into the mental health services where she has lost her kids; her house and her status as a nurse and her

independence, where she was previously functioning very highly. It may be that because of her distress and presentation that she has been unable to cope with these areas of her life but also starkly presents a picture of loss of function and is a grim reminder of current mental health models to return individuals to optimal functioning. Some explanation is found for this by the other CPN: (CPN1/Interview1/ Recovery Focus / Reference 4):

“I think psychiatry is pretty poor at recovery models – getting people back to where they were. They never go back to the way they were, that’s the view and every time they become unwell you take a little piece away. That’s the public view. Laymen will say, “Every time my Dad was unwell, when he came home he was a little bit worse. We lost something,” and you can’t argue with that because that’s usually the case, certainly with psychosis, but with borderline personality it’s all about helping them adapt.”

This account portrays psychiatry’s acceptance with loss of function which appears to be an inevitable consequence of experiencing psychosis that relapse is to be expected and that function will reduce with each relapse. The CPN appears to acknowledge that this is not the case with BPD where the key recovery focus is to enable them to adapt to the diagnosis. The emphasis of psychiatry as captured within this extract is to monitor and stabilise at the expense of improving social and intellectual functioning. I wonder if this explains the current morose within psychiatry about optimising help for service users. To monitor and manage risks rather than re-engage back into society. Is Goffman (1961) alive and well in community rather than in-patient settings? Is there a link with the care programme approach; the dominance of the medical model which is pervading CMHTs? Are these factors conspiring to reduce a recovery focus within CMHTs? CPN2’s account appears to crystallise these components (CPN2/ Interview1/ Recovery Focus/ Reference 1):-

“is I think a greater awareness of himself, or something, a greater view of the kind of picture of himself and being able to look at himself in his relationships and be able to stand back and look at how they are going

on is one thing, you know. I guess a better ability to regulate and manage feelings is another thing, to deal with them whereas the management and regulation of feelings is another thing. Erm, I guess the other area is around employment and direction and vocation and stuff that feeds into his self esteem and things like that, was the kind of stuff that I was kind of thinking of and the whole stuff around understanding and self managing your self harm and other kind of features and the ability to kind of pick stuff off and develop strategies to kind of cope and so on and so forth was the kind of stuff that I was thinking of.

Here the CPN attempts to think about recovery in social terms but returns to the need to cope with self harm as a recurring theme of the discourse. He initially thinks about relationships and self esteem then returns to self harm. He then thinks about work and vocation but returns back to self harm and feelings. This may suggest that the CPN primary focus is on symptom relief at the expense of a psycho social model of intervention which supports the beliefs of enhancing coping as well as engaging back into society with meaningful roles and routes of participation. This therefore focuses attention onto the role of the CPN which governs there professional behaviour with service users.

8.8 Organisational Factors

Teamwork

An interesting finding from the data is the concept of team working with referred service users. Earlier accounts have highlighted the nurses and the medical staff both being involved in the care of of the service user with clear remits of care co-ordinator and prescriber respectively. The following accounts find the CPN pondering the inclusion of an occupational therapist within the care plan (CPN2, Interview 1

Teamwork, Reference 1):-

“Obviously one of the thoughts is that one of the themes that’s coming up with this guy is lack of activity or lack of structure to his days. There’s a bit of that, although he manages to go to the kids, spend time, there is that, but the lack of activity, the whole issue of employment side, you know. It was obviously passing through my mind that I’ve

been thinking about OT, bringing kind of OT in to do that side of it, so that's certainly one thought that I would have, yes."

It would appear that the CPN is currently pondering the inclusion of the occupational therapist and this may have been prompted by the interviewer. Whilst the CPN is focussed on the recovery component, the lack of meaningful activity is obviously a barrier to this and the inclusion of an occupational therapist would firstly overcome this but also add to the assessment of employment options via their specialist expertise. Therefore inclusion of the occupational therapist would benefit the service user's recovery.

What appears striking about the data is the lack of other team members within the intervention package available to service users with borderline personality disorder. This raises the questions as to whether taking on service users on an individual basis is to regulate workload or based on clinical need? Also whether teams are operating as specialist team or at a more general level where the main (statutory) role of care coordinator is undertaken? This former point is articulated by CPN1 on his role of covering for his colleague who is currently off sick and he is looking on after her service user (CPN1 Interview 1/ Organisational Perspectives Reference 10):-

"it just feels like a waste of time because I've done all that good work and he gets on really well with me and then he's going back to somebody else. I don't suppose you put as much emotional investment in a case if you haven't been given the final say, "You are his care co-ordinator"

Here the CPN who is covering for his colleague alludes that he is less invested emotionally with the service user until the manager formally hands over the service user to him to resume full care co-ordination duties. This lack of investment may also work as a protective factor for the CPN in that he is more detached emotionally from the case but may also result in the service user acting out in order to get his needs met.

It would appear that this is not an isolated event and is potentially a recurring theme within the CMHT (CPN1/Interview 1/ Teamwork/ Reference 3):-

“If Steve ever comes back and you’re working with him now you might as well carry on. There are a number of cases where that person’s come back to work and then they go off again, well you just carry on. If that person doesn’t come back to work your Manager’s going to take the easiest route through that rather than going through all the energy of trying to find new workers, just carry on.

It would therefore appear that the needs of service users are dependent upon the availability of the original care co-ordinator, resulting in superficial approaches by the temporary CPN until the case is officially allocated to them. The team values appear related therefore to regulating workload demands rather than meeting service user needs. This will now be further explored.

CPN Workload

The issue of CPN workload is characterised by CPN 1 but is not shared by the other CPNS. This may be because they are nominated care co-ordinators for their service users so have no option but to engage and work with their service users. But there is a marked difference to the stand in care co-ordinator and his approach to managing the service user’s care (CPN1 /Interview1/ Workload/ Reference 5):-

“To be honest I wouldn’t mind continuing seeing him because I know him very well and I can just about manage most things with him. There’s no shocks anymore with him, I know what he’s capable of and how it works, so in that sense I would rather have him sitting on my caseload than somebody who I had to do all the work for, because I’ve done all the work for him, it’s all there, I can just pull it out and look at it.

This extract may be open to two possible interpretations that the CPN has done all the work and is monitoring the service user who is relatively low maintenance or he has come to the conclusion that the service user’s needs have been met and there is need for no further work. This raises the question of why he is not considering either discharge or movement onto to a support worker who could manage some low

intensity work with the service user? With regard to the rest of the team's workload and priorities the CPN remarks (CPN1 / Interview 1/ Workload/ Reference 4):-

“But at the same time it's not good for the team because I'm not seeing new people and they are the priority really, at the minute I don't have space for any, I'm overburdened at the minute. So he'll be seen by the Consultant Dr Smith, who is just starting to get to know him and he's fairly OK with working with personality disorders. He's one of the better consultants at working with them; he's got a lot on his books.

Here the CPN illustrates the tension between the priority of the team to work on new referrals which would mean taking people on following assessment which would entail a whole range of therapeutic and administrative work. In establishing therapeutic relationships with people with borderline personality disorder, the development of professional boundaries are essential when working with category of service user (NIMHE 2003); to prevent burnout and provide containment and direction of therapeutic contact (Swift 2009). The use of boundaries can deepen commitment and develop the therapeutic relationship. The process of relationship development can result in emotional reactions and counter transference within the professional resulting in negative feelings towards the service user (Lewis and Appleby 1988);and can result in additional attributions from the professional that they dislike the patient (Williams and Day 2007). In developing therapeutic relationships with service users with BPD mental health nurses have described service users as being powerful, unrelenting and destructive (Woolaston & Hixebaugh 2008) suggesting that they are a significant challenge to contain within the structure of the therapeutic relationship. Arntz (1994) from a cognitive behavioural perspective suggests that developing an initial relationship with BPD service users may indeed take up to 6 months as trust and the therapeutic relationship is established before utilising any specific cognitive behavioural interventions. This would suggest hat the

early engagement with service users with BPD is indeed crucial to keep them within services and where the CPN is likely to experience emotional challenges which demands resilience from the CPN to maintain the therapeutic relationship. In light of these challenges in working with new service users, it is uncertain from the CPN's accounts whether he will relinquish the service user from his case load in order to focus on new service users. In one sense the service user is predictable, there are no surprises but on the other there is the possible tension of the emotional investment in taking new service users on. However within the discourse his intended course of action is to have the service user monitored by a psychiatrist who will see him on a less frequent basis, this links directly with the fieldwork in which one of the consultant psychiatrist remarked that they tend to see the majority of the cases in the CMHT. This therefore raises additional questions about the delivery of supervision to team members who are working with BPD and also in their case management.

Supervision

Specialist supervision is provided to the team by the secondary care consultant psychologist. This was delivered on a group basis but was recently changed at the request of the team (CPN 2/ Interview 1/ Teamwork/ Reference 3):-

“We’ve got that regularly. We did have it as group supervision. We’ve just changed that because the team wanted that to one-to-one, so what happens is she has a slot booking people to see her in that slot. That’s the way the team have decided to it at the moment”.

From the observational part of the study the team would only appear to meet as a team at the weekly referral meeting which seldom runs for the allocated time with inconsistencies which prevent the team from building its cohesiveness and opportunities for joint working. As a consequence conflict is apparent but seldom worked through or resolved. It would appear that the team is resisting the attempt to meet on a regular basis to provide mutual support and again the suggestion to move to

individual slots would appear to suggest that the team is more like a collection of individuals than a specialist CMHT. The team leader offers an explanation for the move to individual supervision slots (CPN2, interview 1/ teamwork/ reference 3):-

“I think it is time pressure. Not everyone was finding the group format helpful. You would come along and despite the fact that you might ask somebody to come along and everyone was looking in the air, you know, I think people found it difficult. I’m not sure that people felt they could contribute to other people’s discussions or cases sometimes, it might have been useful to listen but you know, we’d done that.”

The CPN acknowledges that there are difficult feelings present within the team but rather than look at ways of exploring and resolving this on a team basis the conflict avoidant strategy is selected, perhaps on a taken for granted level and the account is explained as time pressures on the team. However as the team works to take on more service users with limited opportunity for team support, it is of little surprise that the team experiences sickness resulting in a vicious circle of additional workload with limited support. I wonder whether it should be mandatory for workers to attend a supervision session when working with such demanding and complex service users as BPD?

The team leader reflects upon the interview process with the researcher:
(CPN2 / Interview1/ Supervision/ Reference3):

“ I think the most helpful thing that’s perhaps we’ve done is just to remind me of the importance of just being able to take time to talk about things and reflect on things. How, you know, making time for this supervision and consultation for me is an important thing. Yes. That’s the striking thing that I’ve got from it this afternoon. Yes.

In this extract the CPN appears to value the opportunity to reflect upon the management of the service user. As though he as team leader is putting the needs of both service users and staff before his own needs. The research process would appear to be a chance opportunity for the team leader to have a space to consider the service user and the complexities that he generates. The discourse in the passage seems to be

one of a re-awakening for the CPN of reminding him of the importance of having some time and space away from the caseload and clinic in order to provide some time for him and his service user

Working Better with BPD

As part of the study CPNs were asked what would make them work more effectively with service user with a diagnosis of BPD? One CPN commented (CPN 3/ Interview1/ Working Better with BPD/ Response 1):-

“We get a psychology support once a week, that is really useful. Having some knowledge of CBT and how that works is really useful and being able to know what servicesthere is a referral for Claremont House and it's becauseas long as you have the knowledge to know what services are available for a particular disorder I think it makes it a lot easier, and the rest, we're lucky to have Julie doing training so she offers like the daily... if I wanted to ask a question, she would help me go through that.

Here the account is mainly relates to the provision of psychological therapy in that the CBT approach may help the CPNs' to work more effectively; the psychologist is available for supervision and that the specialist psychotherapy centre is there to provide additional specialist input should a referral become necessary. Perhaps having it described in this order presents to the CPN a model of how to work with the service user psychologically as well as in a stepped care approach to service users being seen elsewhere as well. CBT is delivered, psychologists are consulted and the service user is referred to specialist psychotherapy when that is required.

9 Second Round of Interviews

9.1 Introduction

Within this component of the analysis, discourse was analysed from the perspective of new constructions in both understanding and working with BPD, and these categories are shown in table 3 below. This analysis only focuses on CPN's 1 and 3 who still have their service users active on their caseloads. CPN 2's service user unfortunately disengaged from contact during interview 1 and has not resumed contact and has been discharged from the service and is therefore excluded from this part of the analysis.

KEY PHASES OF ENGAGEMENT	ELEMENTS
9.2 PRE-ENGAGEMENT	<ul style="list-style-type: none">• ADJUSTING TO DIAGNOSIS OF BPD
9.3 SERVICE USER PRESENTATION	<ul style="list-style-type: none">• OVERWHELMED• INTERPERSONAL DEPENDENCE
9.4 CPN UNDERSTANDING OF PRESENTATION	<ul style="list-style-type: none">• CATEGORIES OF BPD• CONSTRUCTION OF PRESENTATION
9.5 CPN'S EMOTIONAL REACTIONS TO ENGAGING WITH BPD	<ul style="list-style-type: none">• FRUSTRATION• ANGER• LIKEABILITY OF SERVICE USER

TABLE 3: CATEGORIES IN ENGAGING BPD (INTERVIEW 2)

9.2 Adjusting to Diagnosis of BPD

New information about adjusting to the diagnosis of BPD by the CPN was illustrated by the following account (CPN3, Interview 2; Adjusting to Diagnosis, Reference 1):-

“But on the back of that, also is about hearing other peoples experiences, you know reading up about what's the latest information out there about the best way forward”.

This excerpt illustrates a positive attitude by the CPN in being able to help her service user with the diagnosis. There is an optimism about working with the service user group and there is also evidence of the relationship between best evidence and its application in practice. However there would also be an underlying drive contained within the discourse of having to or perhaps being able to move forward with this service user group. This CPN's role would appear to be constructed with regard to achieving goals and also in interacting with others to integrate their experiences in working with this service user group. The CPN highlights her reflexive practice by using empirical as well as research knowledge in helping to develop her expertise in working with this service user group. She also attempts to legitimise her role by the adoption of new research findings which further increases the opportunity for optimism in her work by facilitating further attempts to move forward with the service user. According to Daley (2000) a constructivist learning approach to professional development suggests that individuals link new information with past experiences where learning is viewed as a social experience. This supports the CPN's approach to professional development and that the successful integration of this new information with pre-existing beliefs about service users with BPD will enable her to develop her practice. The author also integrates this model with an intuitive model of development such as Benner's (1984) novice to expert whereby novices are said to rely on others for learning and also on written rules. Experts are more likely to make connections between new information and experiences and are more likely to change their practice based on new knowledge that is constructed. These two approaches to learning will be further explored within the following analysis.

9.3 Service User Presentation

The Overwhelmed Service User with BPD

This section will briefly explore changes in the service user's presentation and interventions by the CPN and this will then link to following sections on understanding some of the reasons for this change in presentation and management. The following quotes show that the reduction of two detrimental behaviours to the service user has been replaced by a new self harming behaviour (CPN3, Interview2; Service User Presentation; reference 1):-

So over these last two months she has struggled with a relationship with another service user and she seems to have started mimicking his behaviour”

And (CPN3, Interview2; Service User Presentation; reference 2):-

“ Yes although she has stopped drinking alcohol and taking overdoses its now gone into burning herself which is what the partner does and is quite abusive and assaultive towards herself.”

The CPN's discourse is related to the substitution of self harming behaviours that it has progressed to another method not previously been demonstrated by the service user. There is an attribution to the how the behaviour developed with the assertion that this has been learned from her partner. The behaviour has been copied from her partner with the inference that she is attempting to emulate the partner's behaviour, perhaps as a way of the service user gaining acceptance from her partner whom the CPN identifies that she is struggling to cope with. This behaviour also appears to have had a detrimental effect upon her use of coping strategies. In pursuit of the relationship, she appears to have disengaged from the therapeutic process which has also had a negative impact upon her mood, has resulted in an increase in her self harming behaviour and increases her risk factors. This captures the instability of her mood and motivation and provides questions into the effectiveness of previous interventions she was using for coping. The power of the emotional mind is present within the account and the resultant change of course by the CPN

who charts familiar waters with the service user (CPN3; Interview 2; Interventions; Reference 3):-

“I think we would have to look at risk management. It would have to be, I would have to still keep chipping away at the block in terms of maybe have a look at different types of therapy. I would then be looking at crisis management and what to do in risk plans and contingency plans for this person.”

The CPN has changed her intervention style away from an engaging approach with its focus on teaching interventions into a role of monitoring and surveillance. There is an emphasis on risk management approaches which appears detached and distant from the therapeutic work with the service user. A realisation that this is the phase of separation between the CPN and the service user who is not emotionally invested within the therapeutic relationship or the therapeutic work where her current focus is firmly located in her current destructive relationship. There is less empathy in the account, perhaps a response by the CPN that previous care goals are not going to be achieved and that she is expecting less of the service user. There is reference to looking for the therapy that will help as a way of clinging to some hope that change is possible but this is externalised with the CPN playing a supporting role. There is passivity to the CPN's role which may be a way of providing some form of responsibility to the service user together with a boundary of what is and is not permissible within the confines of the crisis and contingency plans.

The Interpersonally Dependent Service User with BPD

The other CPN provides a commentary on the service user that he is working with and describes the interventions that he is currently using (CPN1, Interview 2; Interventions, Reference 1):-

Physically, look at his medication with the GP. The GP gives him weekly scripts to minimise overdosing. Try to look at what he's got and make sure he's not stockpiling his tablets. Looking at his environment around him. Look what's going to help. Obviously, we've changed his environment – got him a new flat. That's helping him I think, because he's got a lovely couple upstairs who are dead quiet... till they have kids, obviously.”

In the above account the CPN also has a passive role and this mainly consists of keeping a monitoring eye with his service user. There is no active engagement work and the CPN's goal has been achieved in that he has successfully re-housed the service user. However in the last sentence there is the suggestion that interventions are incomplete with the inevitability that the service user will again relapse and come to the attention of the CMHT. The CPN offers the observation that the effect of noisy neighbours which will occur at some point in the future will be the cause of the setback. There is a pragmatic sense to the intervention of re-housing at the expense of the development of coping skills to regulate feelings and one senses the repetition of the intervention when the service user's peace and equilibrium is again challenged. The focus of the work is on harm reduction and there are similar interventions to that which would be found on an acute ward, a familiar frame of reference for the CPN when exploring views on borderline personality disorder: reduce access to means as far as possible by reducing the amount of medication available and checking to see that he is not stockpiling for a future suicide attempt. This discourse would appear to be one which focuses on risk reduction and a new start for the service user who has been in this situation before. There is a repetitiveness to the interventions which gives the impression of an inflexible or restricted range of interventions at the disposal of the CPN.

9.4 CPN UNDERSTANDING OF PRESENTATION

Categories of BPD

Within this analysis the CPNs provide a range of criteria as to how they categorise BPD. In this excerpt the CPN provides a historical flavour as to how the diagnosis has changed over the years (CPN1; Interview2; Categories of BPD, reference1):-

They would say they have borderline personality or they would add something like lately it's become more prevalent to say

“Mostly unstable or narcissistic.” But then it was just plain and simple borderline. I didn’t know what that meant – because they weren’t taught it as nurses in the 80s.

The CPN is reflecting on his experience of working in the in-patient wards, and his discourse is related initially to the frequency to which it appears in the population and is then qualified to include its course in terms of stability which is interspersed with other labels of PD which perhaps illustrates either the complexity or the lack of understanding of the construct. The CPN also illustrates the juxtaposition of the emergence of new categories of mental disorder together with the absence of knowledge, education and training in working with service users with this diagnosis and perhaps explains some of the reasons for the stereotypical views of health workers towards the diagnosis in the absence of such training initiatives.

The CPN instead of a diagnostic framework utilises an alternative framework for describing BPD presentation and begins to build a picture of how this influences his therapeutic engagement with service users from different polarised viewpoints (CPN1 Interview 2; Categories of BPD; Reference 4):-

“Yeah, yeah. Obviously, your high-functioning... your low-functioning person (that’s better that, a bit lower down) – a low-functioning person is somebody who needs to be almost walked through lots of things.”

Here the CPN categorises on the basis of functioning with low functioning being related to the degree of dependence by the service user upon the CPN. In this scenario the CPN adopts a directive stance and is able to dispense advice to the service user which he would appear to readily accept. This categorisation appears to be similar to that of the sick role where the service user is accepting of health and through this dynamic legitimised the CPN’s authority through the therapeutic relationship and interventions. The quote from the CPN appears to endorse in an indirect way that he prefers to work with those on the higher

functioning category and is an interesting comparison with acute in-patient care in that there are marked inequities in power between service user and professionals with service users often functioning at these lower levels of dependence. The CPN goes on to further define and describe the category of low functioning (CPN1 Interview 2; Categories of BPD; Reference 6):-

Dependency issues. So, that's your low-functioning. They need a lot of input... and that guy I was talking about before was quite low-functioning but, you know... He needs more help – he thinks he needs more help than he needs. He can actually get away with a lot less. He's very dependent. That's the real term with him. He's dependent, self-absorbed. But your high-functioning person can be somebody who works, who is integrated, who has a good life – set of life skills, who has a reasonably integrated personality. Not too distorted. Will have a bad day and harm themselves.

Interestingly the lower the functioning the individual the more help they need whether in attending to their perceived needs or in attempting to reduce therapeutic contact with the service user. This dynamic interplays with the need of the CPN to assume direction within the relationship. Conversely the high functioning service user is characterised by his autonomy, maturity but also according to the CPN someone who is not too rigid in his thinking and uses self harm not too seriously to injure themselves but as a way of alleviating distress. It would appear that such categories of service users are unlikely to come into contact with a secondary care CMHT's and be more likely to be managed within primary care. The low functioning service user appears to take a lot of effort to engage and more rigid in presentation with the higher functioning more able to collaborate within the session. The focus of the work is to work with the service user to overcome motivational deficits; avoidance behaviours, reduce anxieties about going out and improve coping with respect to self harm.

The CPN identifies which category he prefers to work with (CPN1 Interview 2; Categories of BPD; Reference 7):-

I prefer the high-functioning, given the choice. Because you can actually get further on because they've got more skill and can look at what you're saying better - can reflect upon arguments and issues around what makes them self-harm.

From this account the high functioning service users are less of a challenge to engage and compliment the CPN's goals of working on specific problems with a shared responsibility for change. The CPN's preference does not challenge the discourse associated with power in that there is no struggle to convince him of new coping strategies as he is more resourceful and likely to respond to the CPN's suggestions. Relating this to his current service user he places him in the mid to high functioning category (CPN1 Interview 2; Categories of BPD; Reference 8):-

He's needy. But... he's active. He's not sitting at home feeling sorry for himself. He's not disintegrated. He's not been admitted to hospital and been distorted by the system.

The relationship with the CPN is characterised by the autonomy of the CPN being respected, the service user will ask for help and advice which will be dispensed and the service user will acknowledge this. The service user does not take much effort now in motivating as he has some social network. The phase of the relationship is one of maintaining the progress they have achieved together. There is stability in the service user's presentation and there is currently no power dynamics being challenged within the relationship. The following extract highlights how this autonomy can be challenged by the service user (CPN1 Interview 2; Categories of BPD; Reference 3):-

I've another guy now and he's one of these people who tries to use me like a toilet. He comes in with a huge ball of pain and he sticks it on my head and expects me to deal with it for him."

In this example the CPN is clearly resisting the efforts of the service user to dump his emotional baggage onto the CPN. This may be underpinned by his own expectations for

how he expects himself to be regarded and treated by the service user. The CPN struggles to acknowledge the service user's difficulty in regulating his feelings and emotions and is unable to provide support for the service user underlined by the use of the word "tries". This delineates that the CPN is providing some resistance and attributes the behaviour as being controlled by the service user whom he generalises as one of a particular kind which serves to dehumanise his existence and disenfranchise him from the interventions that he requires. According to May and Kelly (1982) nurses characterisations of patients are made on the basis of the patient exercising their power and withholding the nurse's authority which challenges their nursing skills and generally makes their life difficult. When this occurs the nurse labels the patient as difficult with the effect of reducing the therapeutic incompetence of the nurse and thus any emotions of the nurse and becomes a face saving activity for the professional behaviour of the nurse. Viewed from this perspective there are a range of structural and contextual issues which affect the nurses response to challenging service users. From a structural perspective this includes the professionalism of the nurse, the organisational norms and rules under which the nurse operates and the constructed role of the mental health nurse. Contextual issues include the exercising of power with the team and within individual interactions with colleagues and service users, and the type of work undertaken by the CPN and with a range of service user constructions. The role of the CPN within this analysis appears to be exercised with regard to their professional goals of helping service users and to achieve therapeutic success in their interventions with service users.

Construction of Presentation

CPN 3's explanation of her service user's difficulty was previously explained with reference to her relationship with men. It had been attributed to this factor by narrowing on the subjective experiences of the service user's distress and these always occurred in her

relationships with men, this was a clear feature of the service user's presentation. A further explanation is offered by the CPN (CPN3; Interview 2; Understanding BPD; Reference 1):-

“She seemed that her sister was much more confident, much stronger, seemed to excel in most areas of her life whereas Sarah was a little less confident, but was trying to live up to the expectations of her sister as the parents doted on the sister more than they did Sarah and it does not help when the family said that Sarah needed all of the attention. She was quite needy and Sarah has always known this and grown up with this.”

And (CPN3; Interview 2; Understanding BPD; Reference 2):-

“And all the way through, her sister got a degree, got married, had kids and she has always been behind despite being two years older and never been able to succeed in her mums expectations. And also Sarah says “this is what it was like when we were kids”. Mum would speak to her sister and tell Sarah. So Sarah sees that all the time.”

The above accounts provide an interesting developmental perspective on the CPN's understanding of the service user's distress. This is explained with regard to early relationships with her parents where the service user explains that her younger sister appeared to be favoured more by her parents. This is used to explain her sister's confidence and success in life in terms of education relationships and family life. In contrast the service user is portrayed as needy and has been regularly reminded of this by her parents with little evidence of meeting her parents' approval and acceptance unless she has been able to achieve perhaps in the same way as her sister. Linking this to her current presentation it may be that this early dynamic is replayed in her relationships where she oscillates between appearing independent in relationships to prove her achievement which she is unable to sustain and then adopts a more dependent stance. The mimicking of burning behaviour may be an attempt by the service user to seek approval and acceptance from her current partner and could be linked to the earlier developmental period. However the earlier account of mimicking the burning behaviour is separated off from this developmental perspective by the CPN and provides only a limited understanding and detached engagement perspective

with the CPN adopting the monitoring role. It may be that by a process of reflection the CPN could integrate these perspectives to provide a deeper, richer and more meaningful explanation for the setback which may enable the service user to understand her emotional reactions and behaviours in relationships and break the cycle of vulnerability that she finds herself locked into.

The other CPN provides an interesting insight into his own view of borderline personality disorder (CPN1; Interview 2; Understanding BPD; Reference 2):-

A member of the family had that issue diagnosed with them. Traits. And that's made me look at it in a different way because I knew the person so well. I knew how they ticked. I knew they weren't like the typical person he would see, but I just think people have to be careful how they throw the diagnosis around for one.

And (CPN1; Interview 2; Understanding BPD; Reference 3):-

And the actual proof of the pudding is looking after somebody who has it and I think you find that they are no different to you or me, they're just have a different capability at dealing with emotionally strenuous activities. You know, and I... I want to enable people. I'm an enabler. I like to get people to do things – I don't want to do things for them if I can. I want to see them engage with a task and prop them up, you know. So... that's what it's all about I think.

In this first account the CPN offers an explanation which challenges traditional views of labelling theory: to look beyond the label and get to know the individual concerned. There is evidence that the CPN's relationship with a family member helped him to question the use of the diagnosis and that it is too freely dispensed by health care professionals. There is surprise and disbelief of the label being applied to his relative due to the CPN's intimate knowledge and relationship with that person which is then used to deconstruct the diagnosis which further helps the CPN to question the validity of the diagnosis in relation to that person. This normalisation approach is articulated within the second extract and provides the CPN with a platform to develop an empathic therapeutic relationship with service users who have the diagnosis of BPD. This enables the CPN to

become more perceptive to the needs of such service users and may affect his behaviour in relationships to become more protective and caring towards as is evidenced by his relationship with the current service user. A critical evaluation of himself reveals that he is driven to help people to enable them to reach their potential. He does this by wanting to do practical things. His therapeutic approach is led by the opportunity to enable people to complete tasks; he needs to be able to support people, to therapeutically hold people in the relationship. This core value seems to drive the interventions which as already reported were highly practical and pragmatic in nature. This core value also appears to get challenged by lower functioning service users who are unable to accept this form of intervention. This may be understood from two perspectives; firstly, perhaps there is some difficulty for the CPN in adjusting to this community focussed role compared to that of the institution. This may also account for the earlier difficulties in working with low functioning service users in the community as this category of service user would be the focus of teamwork in the institution to help control his behaviour and reduce the distress of both service user and professional carer.

Secondly, some service users are rejecting of the approach and therefore may be rejecting of the core value of the CPN. When this occurs then the CPN's empathic and non judgemental approach appears to evaporate and the waves of unstable stereotypical labels that can be applied to BPD quickly emerge and wash over the CPN to create a flood of powerful emotions which can quickly erode therapeutic encounters.

9.5 CPN'S EMOTIONAL REACTIONS TO ENGAGING WITH BPD

Frustration

Having identified frustration as one of the key emotions experienced by CPN's when working with this service user group it was interesting to notice how the CPN's coped with that experience. As previously identified one strategy employed by the CPN's

was to share responsibility with the service user (CPN3, Interview 2; CPN Emotions; Reference 3):-

So I'm very clear about saying, I'm not quite sure where we were going with this. And once I've vented that quite openly it reduces my emotional responses, and it's about sharing that responsibility".

This strategy employed by the CPN with a service user who is prone to crisis in the form of overdoses, avoids assuming responsibility for the service user's overall behavioural management. By being assertive in the relationship and perhaps being honest with not only the service user but herself she is able to acknowledge the limitations of her own role as expert and shares the responsibility for the problem and solution with the service user. By taking this stance she appears supportive towards the service user without being confrontational which reduces her own expectations for resolving the immediate crisis. It would appear that this approach requires an emotional maturity on the part of the CPN with good self awareness with lower expectations for her own role, thus determining a slower pace of change with the individual service user.

The thrust of the discourse of the CPNs' interviewed to date relate to their goals of attempting to achieve successful outcomes with service users whether it be to reduce self harm or improve motivation when service users feel depressed. The most overwhelming emotion experienced by the CPNs' was that of frustration when goals were not achieved (CPN3 Interview 2; CPN Emotional Attributions; Reference 3):-

I think its because that they have so many different traits that you cant sometimes see an end to, so having impulsive behaviour sometimes cannot be changed at all despite therapies or input, and from a professionals point of view it becomes quite frustrating and quite challenging and you have nothing left to offer, what else can you offer? And I think that's where my frustration comes from.

Within this account the CPN acknowledges that her frustration appears to be the result of being unable to accept that her service user's behaviours can't always be changed.

Interestingly she places much emphasis upon the role of techniques in change and that somehow without these strategies she has nothing else to offer. There is no acknowledgement of the role of her relationship with the service user in offering empathy and support and the important role that so called non specific factors may have to play in helping the service user to accept herself and the aspects of her presentation that she clearly finds difficult to manage and contain. It would therefore appear that when the CPN's goals are thwarted by highly challenging service users and that this results in a range of emotions which is clearly challenging for the CPNs. In the above account the CPN attempts to minimise the personal impact upon the feelings for her by emphasising the term professional. This would appear to be a more acceptable level of feeling, that it is permissible to professionally feel frustrated and minimises the effects of the emotional reactions on the CPN which may well be a protective factor for the CPN.

Anger

In contrast another CPN who is working with a complex and challenging service user reveals the following encounter and resultant emotions (CPN1, Interview 2; CPN Emotions; Reference 3):-

“He said “Well, go if you can’t cope with it because I don’t do this, I do this.....” grabbing a Stanley knife out of his bureau and slashing his wrist... which made me feel awful. And, what do you do with these feelings? Where do you go with them? You go home thinking... I keep seeing him do it.”

The CPN finds himself in an immediate crisis situation with the service user, there are no clear boundaries and the service user is providing intimidation to the CPN by questioning his ability to tolerate painful emotions and proceeds to harm himself. This is clearly traumatic and anxiety provoking for the CPN. The service user appears to be assuming control of the session and for how the CPN will emotionally respond to the situation. There is also a lack of support for the CPN and his emotional state as though there is no clear and

accessible framework within the team to provide support at this vulnerable time. Allied to this is the lack of clear supervision to enable the CPN to contain his feelings and to be able to ventilate his experiences in a safe and supportive environment. It is as though there is no recognition within the team of the high emotional cost involved when working with this service user group and leaves the CPN with a range of conflicting thoughts and feelings (CPN3, Interview 2; CPN Emotions; Reference 1):-

“You go through a – initially anger and confusion, and, generally antipathy. You’re not supposed to have those feelings because that’s not therapeutic, that you have an antipathy towards them and you don’t like them.. You dislike them. But you don’t dislike them... I don’t suppose, professionally, like and dislike it’s not an issue. You look after them. You deal with them.

In this excerpt the CPN is coming to terms with the experience and his emotional reactions to the service user. He is ambivalent about whether he likes him and other service users with this type of presentation. There is however a realisation of his caring role and this appears from a professional perspective a realisation that the service user needs help and it would appear that the emotional reactions appears to be directed at the service user but may in actual fact be focussed on himself for experiencing the antipathy which is contrary to his own expectations. Watts and Morgan (1994) state that mental health workers make unrealistic expectations that they should be able to love and care for all of their service users regardless of presentation and states that these are traps that workers fall into with resultant negative emotional upset. Morgan (1979) in his review of suicides in psychiatric in-patients coined the term “malignant alienation” to describe deterioration in staff patient relationships where there was a withdrawal of sympathy towards the service user with negative feelings being portrayed which ultimately resulted in them committing suicide. In exploring the concept further Watts and Morgan (1984) describe staff factors which bring about these responses include strong expectations within staff that they are able to treat all service users; know all there is about the service user and their management and an ability

to always be able to empathise with service users. They hypothesise that when these defences are breached the professional is left helpless and then adopts a retaliatory approach to coping with their helplessness. This means that a failed treatment alliance is further attributed to the service user resulting in an environmental culture of invalidation towards the service user(s) experience by the majority of health care staff.

Wright et al (2007) state that health care staff working with Personality disorder develop primarily constructions of service users as a further manifestation of self preservation and they have developed an educational perspective aimed at raising awareness into such constructions and then in a collaborative process with the learner deconstruct these descriptions thus enabling a reconstructed version which is more helpful to both service user and mental health worker. This they contend can be achieved through self reflection and development of self awareness. Despite their acknowledgement of the role social construction plays within the maintenance of such stereotypical views, the authors fail to acknowledge how the social environment of trainees' workplace may need to be challenged or worked upon in order to facilitate the deconstructive processes that they recommend. In constructivist learning terms the individual will need to address pre-existing knowledge with new learning experiences in the social context of the workgroup to facilitate change. This is supported by Kelly and May (1982) who contend that social constructions are formed as a consequence of the dynamic interaction between two or more people and this may include the nurse and service user but can also be extended to include other team members and how for example the CPN role is constructed within the team. For example within the observational component of the study other team members could implicate the CPN within the care of service users by suggesting a role in medication monitoring for both compliance and side effects. Therefore the allocation of the nurse to the service user may in itself denote power imbalances and conflict particularly if the CPN

does not volunteer for involvement but is requested to so by other more powerful members of the team.

Having explored the emotional reactions involved when there is a mismatch between CPN expectations and service user presentation, attention will now be focused on the emotional reactions that occur when a match of service user and CPN style occurs as in the case with the high functioning service user (CPN1, Interview 2; CPN Emotions; Reference 5):-

“With him, he kind of makes me feel quite protective towards him.”

There is evidence of the caring relationship with the service user; the dependence that the service user demonstrates is matched by the protectiveness of the CPN. There is a taking on of responsibility for the service user which is manifest by the directive nature of the interventions and the advice dispensed. There is a hesitancy in the CPN disclosing these positive feelings as though he should be emotionally neutral in his service user encounters. As there is uncertainty in expressing negative emotions with challenging service users there is also a reserved feel to this acknowledgement. It is as though there is some awkwardness in the processing of emotional experience and that this is ventilated through the enthusiastic interventions for the service user. This is a caring response and it also appears awkward for this to be identified in the CPN's world of mounting caseloads and pressure to increase the throughput of CMHT's to satisfy the ever increasing demands of referrers to the service.

Likeability of Service User with BPD

The CPN reflects on his experience with a service user whom he would categorise as being low functioning, challenging to work with and describes some of the difficulties that he experiences in the relationship with a service user who earlier attempts to use him as a toilet: (CPN1, Interview 2, CPN Emotional Attributions, reference 4):-

You dislike them intensely. You think... You know, some people don't have nice personalities. They're not likeable. There's nothing you can get a hold of that you could say "I like that about you".

In this extract the CPN is working with a service user that is difficult to motivate and is emotionally draining for the CPN to work with. There is no reciprocity of positive feelings from the service user to the CPN and it is difficult to initiate a relationship with the service user. There is little or no therapeutic relationship with the service user and the CPN has experienced negative feelings prior to the visit. The service user clearly challenges the authority and autonomy of the CPN and does not legitimise the CPN role by being difficult to get on with and also to see any positive changes;. The service user is therefore challenging the expectations and goals of the CPN that he should attempt to help the service user to overcome such deficits associated with his low mood. The CPN makes an evaluation of the service user that he is therefore unlikeable and finds it difficult to find positive examples in the service user's presentation. There is clear frustration within the CPN and there is also very little empathy towards the service user with resentment being expressed by the CPN at having to attempt further interventions. The CPN develops his emotional experience of the service user and it's effect upon the relationship (CPN1, Interview 2, CPN Emotional Attributions, Reference 5):-

"You don't want to be with them. You don't like them...It stirs up loads of negative feelings and horrible feelings inside you. You think "this is not what I like to feel. This is not like... This is not what I want to be" you know? I'll do anything but be a CPN for that split second".

The CPN locates the difficulty in service user presentation and the degree of difficulty in making progress with the service user with a range of personal emotions that he experiences and this appears to result in him evaluating the service user in negative terms. There is clearly a mismatch between his own constructions of how he should be. This challenges the autonomy of the CPN and makes him question whether he is effective at his work. There appears to a tension in the professional role of the CPN and how this is

translated in practice with this service user with key themes being present that challenge the CPN of being in control and being competent with the service user. Due to the service user presentation this results in the dual perspective of the CPN feeling both incompetent and out of control of his own emotions which has a negative impact upon the relationship in that he does not want to be with the service user. There is also a negative evaluation of the CPN's emotions when attached to the service user which is then transferred back onto the service user and has the potential to label the service user as difficult. This may further stigmatise the service users from the CPN, and sets up additional negative emotions on future visits. Due to the lack of empathy it may also set up additional despondency within the service user in that he may not feel that the CPN is interested in helping him which may make the service user feel further alienated from the CPN and thus a range of negative expectations may occur creating further distance and negative evaluation of both service user and CPN from each other's perspectives. There is then the additional burden that this creates within the CPN in that when reflecting on these experiences he identifies that these personal feelings are therefore antagonistic towards the professional construction of the CPN (CPN1, Interview 2, CPN Emotional Attributions, Reference 6):-

“...because you shouldn't be thinking like this in terms of disliking that person so much and not being able to help them.”

Here the CPN articulates that his personal feelings are contrary to the professional role and the need to convey a non judgemental attitude towards all service users even those which present us with profound engagement challenges. However there is a sense of regret that despite not being able to like the service user that the CPN was unable to provide help and feels let down by his own inadequacies as a mental health provider. In the current world of evidence based practice where CPN's need to deliver effective interventions this is a reminder that not all service users are able to utilise such approaches and that the nurturing of a therapeutic relationship is perhaps the platform in which to build future interventions.

What value of the effectiveness of a sound therapeutic relationship with difficult to engage service users who present significant risks to themselves? There is an irony here that perhaps the best thing to do with this category of service user is to attempt to do nothing. This can be explained with respect to the “sociology of the interesting” (Davis 1971) where propositions can be considered to be true when examined from the converse and opposite viewpoint. An example is that a general phenomenon such as Oedipus complex is in fact a local phenomenon as it does occur in all societies. Applying this principle with regard to BPD, where the desire for staff to be clinically effective they have to do a range of interventions such as psycho-education, coping strategies etc whereas providing a supportive relationship may be considered as employing no active interventions but actually can be more effective with BPD service users than evidence based interventions such as Dialectical Behaviour Therapy (Clarkin et al 2007).

The key aspect of the CPN’s construction of what determines effective working with this service user group is further explored in the following extract (CPN1, Interview 2, CPN Emotional Attributions, Reference 10):-

Undeserving? Of my time? Or healthcare? I don’t know. Well, somebody who’s like that is like.... It stirs up a load of feelings in everybody I think. It’s like, well...”what the hell are we going to do with this man?” That’s what I think,. Well.. people don’t fit. He doesn’t fit into any of our pegs. He’s horrible. And you know.. You can’t like him. If you find me a way of liking him, I can help him a lot more.”

The CPN develops his evaluation of the service user by inferring that perhaps if he is unable to make progress or accept help then he may well be undeserving of help whether from the CPN or the mental health service as a whole. This underlines the hopelessness that is felt in working with this category of service user. Perhaps this is a further way of protecting the CPN from emotional upset? Perhaps this can also be viewed as the CPN’s frame of reference where he believes that he does not deserve to be treated in this way by

his service users who represent an additional expectation that is challenged by the service user?

There is a further inference that the label applied to the service user creates dissonance within the team of having to work with service users that do not fit with their own categorisation related to severe mental illness but also more importantly of those who are low rather than higher functioning.

Both these explanations and inferences serve to create a negative view of this type of service user presentation which can cause further alienation from the CPN and wider CMHT, as the CPN may relate the service user presentation as a way of further implicating the service user as difficult and thus seeking to preserve his own status as attempting to engage the challenging service user.

A surprising finding from the second round of interviews was the strengthening of the category of Likeability of the Service User, and this appeared to further highlight the tensions in the professional role and expectations of the CPN to have genuine empathy for service users and the intense emotional reactions that can be invoked whilst working with this service user group.

10. Conclusions

10.1 Implications for Practitioners working with BPD

This thesis was focussed on the following research questions:-

- What is the nature of mental health nurses' beliefs towards service users with a diagnosis of BPD?
- How do mental health nurses' beliefs towards service users with a diagnosis of BPD affect their therapeutic relationships with this service user group?

The results of this study has enabled better understanding into mental health nurses beliefs about working with service users with a diagnosis of BPD and has led to the development of a model of understanding into how mental health nurses attributions and evaluations of service users with BPD can mediate therapeutic engagement with them which can lead to their continuing engagement or disengagement from services. Whilst it has been reported elsewhere in this thesis that deviancy is socially constructed and related to moral reasoning of for example psychiatric staff towards service users with BPD, Young (2009) contends that the process of deviancy amplification whereby the negative characteristics of a sub group are emphasised and contributes to ongoing stigma. Whilst it is not the intention of this thesis to utilise this process with regard to the construction of BPD, as both positive and negative aspects of constructions of BPD have been reported upon. However there is a focus on the potential negative pathways towards alienation of BPD by professional staff as a means of developing reflexivity into this phenomenon and the development of potential strategies to combat negative stereotyping. This is shown in Figure 1 below.

The model was developed utilising the method of Kitwood & Bredin (1992) who developed models to explain the concept of personhood in dementia care and also the process of deteriorating neurological impairment as a consequence of the social routines that occur in the management of the disease. Kitwood & Bredin (1992) observed the social processes and experience of care for dementia sufferers which consisted of taken for granted assumptions and behaviours where the focus of attention of psychiatrists, nurses, and psychologists was on the brain and the degenerative processes. Through his work he observed that deterioration in mental processes usually followed rather than preceded institutional care ie admissions to nursing homes and hospitals. It was the care processes rather than the degenerative processes associated with the disease and by focussing care practices onto developing human relationships with the person with dementia then their neurological degeneration could be offset and the role of the other was used to replenish the personhood of the individual as a method of holding the individual together to maintain social and psychological functioning. Utilising this approach helped to make sense of the interactional effects of care co-ordinators working with service users with BPD.

Despite the similar outcomes associated with the application of the model to dementia and BPD in describing the malignant social psychology and symptom deterioration associated with the relationships between professionals and service users with those diagnoses,. There are several differences in use in this study. Firstly a more detailed construction of the social relationship emerges and this is clearly linked to the CPN's attributional framework and constructions of the service users' rather than the discourse associated with dominant biological model inherent within the dementia study. Secondly this study is mainly concerned with social process and

showed the possible effect of this on patient outcomes in that they disengaged from therapeutic work, whereas Kitwood was more able to demonstrate the impact of social process on the neurological impairment of people with dementia. Thirdly the model within this study is more uni disciplinary which focused predominantly on the work of CPN's compared to the multiprofessional focus of the dementia study.

The implications of this model will be discussed for how we need to organise services and practitioners to effectively meet the needs of service users with a diagnosis of BPD. In addition the professional roles of CPN's will be explored in order to maximise their potential when working with service users with a diagnosis of BPD. These will now be explored.

Model of Understanding CPN beliefs when working with BPD

The nature of mental health nurses' beliefs towards service users with a diagnosis of BPD relate to two main positions, firstly a negative tendency and secondly a positive disposition. These will now be discussed in more detail.

Construction of BPD

Mental health nurses' beliefs are constructed by previous exposure to service users with BPD and in turn are constructed by those experiences⁸. The diagram in figure 1 shows the processes by which these constructions occur. The starting point is the categorisation of BPD that the CPN has established via past experiences of working with this service user group either in the community or inpatient settings (CPN1, Interview 1 Understanding BPD, reference 6). This is obtained on first impressions on being allocated to the service user and also in starting to work with the service user.

⁸ Firsthand experience is further mediated through sense of self and sense of professional identity (and role security) as a nurse. Such ontological certainties are inextricably linked to experiences of socialisation into the professional role. The influence of these matters, whilst not signalled out here in the current study for special analytic attention, were inevitably ever-present in the documented data instances provided to illustrate specific points.

Within this study such categorisations were related to the diagnosis itself with variants of BPD to include emotionally unstable personality disorder; categorisations in terms of therapeutic relationship either dependent (CPN 1 Interview 1, Engaging BPD/Service User Factors reference 4) or who is in power or control (CPN1 Interview 2; Categories of BPD; Reference 3) of the relationship; behavioural manifestation in terms of either self harm or frequent crisis (CPN3, Interview2; Service User Presentation; reference 2); and whether the service user was of low or higher functioning in terms of the relationship between the problematic behaviours or more functioning aspects of the individual (CPN1 Interview 2; Categories of BPD; Reference 6). Impressions and categorisations are also generated which relate to understanding of the concept of BPD with links to hereditary factors in the development of the condition; the inflexible and intransigent nature of the course of the disorder which together can potentially predispose the CPN to pessimism at the prospect of working with such service users (CPN2, Interview 1, Service User Needs Reference 2)

Preferences of CPN to Category of BPD

Implicit assumptions are held by the CPNs as to his or her particular preferences in working with specific categories of BPD. Such preferences are contained within taken for granted knowledge and social routines of the CPNs' and this study has enabled these to be articulated within the context of the therapeutic relationship. These preferences are held by the CPN but perhaps not always shared with other members of the team which can have different outcomes. Firstly this may be related to self preservation where the CPN gives the impression to the team of being reliable and able to take on and manage more complex service users with more challenging and demanding needs (CPN 1/ Interview 1/ Workload/Reference 5). However, being

unable to acknowledge any difficulties in working with particular categories results in lack of supportive opportunities for the CPN to express his or her concerns and also to receive support from other team members in the form of team supervision or in not being allocated a particular type of service user (CPN 2/ Interview 1/ Teamwork/ Reference 3). This lack of supervision and lack of a reflexive approach to self awareness may further compound the effect of hidden preferences on service user allocation and possible teamwork with colleagues.

Mismatch of Category to Preference

As the early therapeutic encounters develop with time and the frequency of sessions the mismatch between the presentation of the service user and the preference of the CPN begins to emerge. This mismatch may take the form of increased power struggles within the relationship (CPN 3, interview 1, Engaging BPD, Reference 10) ; a mismatch over the goals and pace of the therapeutic approach (CPN 2, Interview 1, Emotional Reactions to Service User, Reference 2); the presentation of the service user from an emotional perspective with the service user becoming more hostile within the relationship; their identifiable problems or the type of interventions and relationship style of the CPN: that is one which is empathic or one which is information gathering and questioning in nature (CPN3; Interview 2; Interventions; Reference 3). The service user may also demonstrate resistance in this early phase with missed appointments (CPN 2, Interview 1, Disengagement, Reference 2); an increase in self harming behaviours (CPN3, Interview 1, Emotional Reactions to Service User, Reference 7), an increase in other impulsive behaviours such as increasing their alcohol usage (CPN 3, Interview 1, Service User Needs Reference 6). From the CPN perspective there are attempts to persevere with their preferred style which may be related to gathering background information (CPN 2, Interview1, Care

Goals, Reference 4); select the category of intervention; provide psycho education about problematic behaviours (CPN 2, Interview1, Understanding BPD, Reference 11). At this stage the involvement of additional team members may be enlisted such as medical staff and joint appointments arranged (CPN 3, interview 1, Engaging BPD, Reference 4); and additional information sought from other agency involvement (CPN 3, interview 1, Engaging BPD, Reference 12).

Goals and Expectations of CPN Challenged

The focus of the work of the CPNs is problem focussed and goal directed (CPN 2, Interview1, Care Goals, Reference 4); (CPN1, Interview 1, CPN Role, Reference 12); (CPN 3, interview 1, Engaging BPD, Reference 4). The main thrust of their approach and interventions is to move the service user on and get the work done. To this end the emphasis is on risk management (CPN3; Interview 2; Interventions; Reference 3); problem solving strategies (CPN1, Interview 1, CPN Role, Reference 12) and pragmatic approaches such as re-housing or dealing with family related issues etc (CPN1, Interview 1, CPN Interventions, Reference 3). They are focussed on recovery and on discharging the service user (CPN3/Interview1/ Recovery Focus / Reference 3). There are pressures on CMHT's to increase their throughput of service users and these pressures influence the focus and philosophy of the team in treating service users who flow through the care system. Service users with a diagnosis of BPD can find it difficult to cope with change; they have pervasive problems in their relationships with others and increasingly find it difficult to trust others and to accept responsibility for change (CPN 3, interview 1, Engaging BPD, Reference 3). These factors together with their emotional instability and self harm as an attempt to regulate their feelings (CPN 2, Interview1, Understanding BPD, Reference 11); (CPN 1,

Interview1, Understanding BPD, Reference 10); (CPN 3, interview 1, Engaging BPD, Reference 12); combined with low mood indicate that the traditional approach of the CPN and CMHT represents several tensions and challenges not only to the expectations of the CPN but also to the social world in which he or she operates.

CPN Emotional Reactions

The most frequently encountered emotion was one of anxiety and frustration when working with the BPD service user when tensions were apparent in the relationship (CPN 2, Interview 1, Emotional Reactions to Service User, Reference 4). This is related to the actual or threat to the achievement of goals and interventions of the CPN. The thwarting of the expectations and goals of the CPN also resulted in irritability and anger within the CPN which was then attributed to the service user (CPN3, Interview 2; CPN Emotions; Reference 1).⁹

Attribution to Service User

The emotional reactions of the CPN are attributed to the service user and are commonly known as counter transference or the feelings initiated in the therapist or caregiver by the service user (Watts and Morgan 1994). Maltzberger & Buie, 1974 state that these feelings within the therapist take the form of malice and aversion with the latter being at the heart of the alienation of the service user. Such explanations in the field of psychotherapy locate the emotion within the service user. Attributions made at this stage relate to the service users being difficult or troublesome. There is no focus of the CPN on their understanding of BPD or service user presentation and their attributions are rooted in emotions and likely to imply a judgement towards the

⁹ In psychodynamic terms these emotional reactions might be considered as instances of Transference. NB however, that the current study makes no such theoretical claims and was concerned to merely document observed and reported instances of interaction, and theoretically speculate how these might be enacted so as to produce certain 'constructions' of BPD identity.

service user. The focus of CPN attention is therefore threat related (CPN3, Interview 1, Emotional Reactions to Service User, Reference 5) and as a consequence selectively locates the source of the distress within the object causing the distress: the service user (CPN3, Interview 1, Emotional Reactions to Service User, Reference 8).

Evaluation of Service User

The continuation of emotional arousal of the CPN together with attributions to the service user results in the CPN evaluating the service user in a negative light. Such evaluations of service users at this stage are related to the likeability of the service user and would appear to represent the first observable aspect of CPN alienation from the service user with BPD.

This evaluation would also appear to represent a conflict for the CPN with accompanying dissonance for the CPN. On the one hand the initial distress is explained by way of the service user's presentation. An example from CPN1, Interview 2, CPN Emotional Attributions, reference 4:-

You dislike them intensely. You think... You know, some people don't have nice personalities. They're not likeable. There's nothing you can get a hold of that you could say "I like that about you".

However the evaluation that they may be unlikeable presents further distress for the CPN as this is counter to the construction of the CPN as a professional where the professional image is one where no negative feelings are expressed towards service users (CPN3, Interview 2; CPN Emotions; Reference 1):-

"You go through a – initially anger and confusion, and, generally antipathy. You're not supposed to have those feelings because that's not therapeutic, that you have an antipathy towards them and you don't like them.. You dislike them. But you don't dislike the."

However this would appear to be offset by the evaluation of the service user as unlikeable and the overriding concern of the CPN is to reduce the distress that he or she experiences in working with the service user.

CPN disattends to service user needs and emotions

The construction of the service user as unlikeable is further constructed by the behaviour of the CPN where there is more focus on the location of distress namely him or herself (CPN3, Interview 2; CPN Emotions; Reference 1). Due to the location of attention on the self, there is less emphasis on attending to the therapeutic relationship and reacting to the increasing needs of the service user (CPN3; Interview 2; Interventions; Reference 3). As a consequence the service user demonstrates heightened emotional experiences which compound the CPN's attribution and evaluation framework. At this level of intervention the CPN may be doing the basics with the service user. Interventions such as routine monitoring; risk assessment and management, contingency planning; liaising with other professionals and care co-ordination tasks. There is less empathy towards the service user and can feel like going through the motions or attending to the basics within the care plan (CPN1, Interview 2; Interventions, Reference 1); (CPN1 Interview 1/ Organisational Perspectives Reference 10).

Service user labelled as difficult

With less therapeutic involvement and positive movement of the service user in the direction of the CPN's goals and expectations, there is less progress with the service user. This together with the unresponsiveness of the service user to CPN intervention results in further evaluation and labelling of the service user as difficult. (CPN3 Interview 2; CPN Emotional Attributions; Reference 3):-

I think its because that they have so many different traits that you cant sometimes see an end to, so having impulsive behaviour sometimes cannot

be changed at all despite therapies or input, and from a professionals point of view it becomes quite frustrating and quite challenging and you have nothing left to offer, what else can you offer? And I think that's where my frustration comes from.

This realisation of the complexity of the service user highlights the inadequacy of the CPN's interventions in achieving his or her goals of moving forward with the service user. The construction of difficult is an acknowledgement of the CPN that the service user is not accepting their role within the therapeutic relationship as accepting of help and therefore does not legitimise the CPN's role of professional helper. This construction of difficult goes beyond the concept of challenge which can be a stimulating endeavour in one's work. Instead this exemplifies the enduring nature of the power struggle that is occurring between service user and CPN and a realisation that this battle may be one which the CPN will find difficult to conquer.

CPN Beliefs

Amid the current battlefield that they find themselves part of, the CPNs' evaluation appears to turn inward onto him or her self, realising that their usual approach to meeting service user needs may be met with further service user resistance. This activates a range of beliefs and consequences. Firstly there is the self evaluation of feeling incompetent that they do not possess the range of skills and interventions (CPN1, Interview 2, CPN Emotional Attributions, Reference 10) in order to move the service user forward further challenging their goals and expectations and increasing their sense of frustration with the service user. This results in a further loss of control or power in the therapeutic relationship where the directive approach previously applied by the CPN is no longer permissible. The service user no longer endorses their passive role and threatens the authority of the CPN. This loss of CPN autonomy together with loss of control results in further anger and frustration and builds the

negative construction of the service user. Additional beliefs of helplessness (CPN3, Interview 1, Emotional Reactions to Service User, Reference 6) are activated that the CPN is unable to help the service user and that the service user is unable to be helped. This further questions the CPN authority and effectiveness in the relationship. In addition the CPN may further explore aspects of themselves which may have contributed to the helplessness and incompetence in terms of their own skills and or self concept such as how they look or how they come across to others, for example the service user.

Loss of Empathy and Understanding

With the CPNs' focus on their beliefs and emotions associated with helplessness and incompetence, further evaluation of the service user occurs with additional judgements made about the likeability of the service user with the negative judgement that they are unlikeable further constructed (CPN1, Interview 1, Emotional Reactions to Service User, Reference 5). This construction appears to replace or ignore previous constructions of personhood (CPN1; Interview 2; Understanding BPD; Reference 2), understanding into the development of the disorder within the individual, and the identity of the service user reverts to a stereotype of BPD. As a consequence of this and the accompanying anger and frustration that is experienced, the CPN is therefore unable to maintain an engaging and empathic approach to the service user. The CPNs appear unable to separate the negative feelings experienced in their relationship with the service user from their understanding of the service user's presentation and relationship style and the consequences of this on others ie the CPNs themselves.

Mismatch in CPN Construction of Professional Role

The professional role of the CPN as a caring professional who is able to collaborate with service users and develop recovery orientated and de-stigmatising interventions

(DH 2002) with service users is challenged in their relationship during therapeutic impasses with service users with BPD. There is a tension in the feelings of helplessness and the judgements of not liking their service users which is antagonistic to the professional role of the CPN which generates further feelings of anger and frustration (CPN3, Interview 2; CPN Emotions; Reference 1). The experience of working with service users who challenge the professional role and status of the CPN can undermine the therapeutic alliance and result in further alienation of the service user (CPN1, Interview 2, CPN Emotional Attributions, reference 4).

Further mismatches are experienced by the service user with a diagnosis of BPD in that the service response can be hostile (Fallon 2003) and contrary to the rhetoric of the Personality Disorder Policy Implementation Guide (2003) that Adult mental health teams should attempt to meet the needs of service users with a diagnosis of BPD but acknowledges that all too often such services are reluctant to engage with service users due to lack of training and complexity of presentation. Newton-Howes et al (2008) found that CMHT's tended to rate service users with BPD as harder to manage and to work with. This conclusion being attributed to the stigmatising nature of the label.

Services should also be configured to provide a team approach to meeting the needs of service users with clear and specific roles, however the results of this study has shown that this team consists of the CPN as the mainstay of therapeutic contact with some additional support of medical staff in providing medication and /or additional consultation and support. Despite the need of a clear holistic team approach there are further mismatch in service provision in the narrow focus of care provided in contrast to the potential wider focus of a specialist team which could additionally comprise of psychological social and occupational perspectives (NIMHE 2003).

Service User Undeserving of CPN's Attention

The construction of the service user with BPD further develops with the CPN being unsure of how to respond to the current situation; the questioning of the diagnosis in terms of whether it is a genuine mental illness with the further questioning and attribution of whether the service user should be seen at all by the service. The construction moves from the CPN intervention to the service as a whole as if to question the validity of whether they are deserving of intervention (CPN1, Interview 2, CPN Emotional Attributions, Reference 10). This is directly related to the expectation of the service and the legitimisation of the CPN role and the accepting of help by the service user from the CPN. However the treatability test within the amended mental health act states that treatment for a patient must be likely to alleviate or prevent deterioration in the condition (MHA 2007). Such treatments are available (NICE 2009) for BPD and available within secondary mental health services and this frame of reference may contribute towards challenging this construction of BPD as undeserving.

Dissonance with Diagnosis

Despite the government rhetoric that BPD is no longer a diagnosis of exclusion the service user with the diagnosis creates a range of upsetting emotions for the CPNs during their ongoing relationship with the service user. The diagnostic category is understood in the neutrality of the assessment meeting but in the intense nature of a therapeutic encounter the label is one which does not hold resonance for the CPNs. This is related to the questioning of the diagnostic category which is poorly understood together with the self concept of the CPN whose worth is symbolised in terms of his or her competence in helping service users' travel through the secondary care CMHT service.

Label applied to service user as difficult or troublesome

The CPN categorises the service user in wholly deviant terms rather than on established frameworks whether these are diagnostic or recovery focussed. In order to reduce this discomfort additional categories are formed in which to slot the service user's presentation into. These categories further stigmatise the service user and increase the social distance between the service user and the CPNs. These are related to the desirability of the service user and these are in negative terms such as horrible; difficult; troublesome.

Team concur with label

The categorisation of the BPD service user is complete if and when the label is endorsed by the team. This occurs through the process of case discussion and feedback within the assessment meeting and was observed during the fieldwork component of the study: (Defined Categories P81):

but as a consultant remarked could have Aspergers syndrome (**type category**) with the other consultant commenting that she is rigid and resistant (**associated behaviours**) and that her anger (**behaviour**) could be related to a emotional unstable personality disorder (**deviant**). A CMHT worker comment sounds like trouble (**general category**). The decision is to offer an assessment as this seems an interesting case and see what is going on.

During this discussion the above comments from a mental health worker went unacknowledged and unchallenged which may be understood as an example of taken for granted knowledge within the team and endorsed by the team. Thus the label of personality disorder attracted further stigmatising endorsement by the individual which may be characteristic of how the team related to the label in a formal context.

In addition, the CPNs interviewed in this study, endorsed the role of supervision but CPN 2 related that the team had moved away from a team approach to

an individualised account with the explanation that the team did not find it helpful and that were unable to contribute to others' discussions as previous suggestions did not help (CPN 2 interview 1/ teamwork/ reference 3). This would further suggest that the team had tiredness with such service users whom they could not help and represented further helplessness to the team which they attempted to cope with by avoidance of such meetings and discussions. Such negative stories of past encounters may colour future workers endeavours to work therapeutically with these service users and may contribute to further service user experiences of invalidation and stereotyping.

The Construction of Alternative Coping with Frustration

Results of this study showed that the CPN's could also construct alternative ways of coping with negative feelings associated with working with service users with BPD. These constructions are shown in Figure 2 below.

In comparison to figure 1, the following model is less complex in nature as it would appear to follow as a consequence of the relationship transformations described in detail in the previous sections. That construction explored the various facets that combine to produce more negativity by the CPN's towards service users with BPD, contributing toward stigmatising beliefs which were out of keeping with the professional construction of the role of the CPN and of the construct of BPD. The therapeutic discourse associates with the model in figure 1 together with the impact of the team discourse represented tensions in working with BPD which manifest itself as

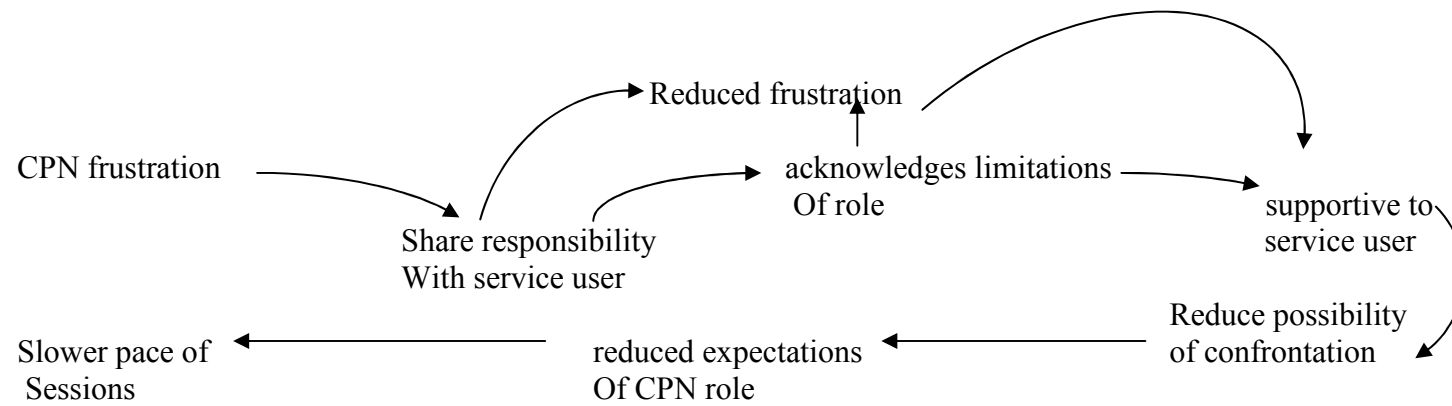


FIGURE 2: ALTERNATIVE APPROACH OF CPN's COPING WITH FRUSTRATION

tension to be resolved in the model. Figure 2 therefore appears to represent an approach to enable the CPN's to resolve the emotional impact when working with service users with BPD and will now be explored in more detail.

Share Responsibility with Service User

As explained in the earlier discussion about the development of negative feelings the CPNs drew on their existing knowledge of the management of service users with a diagnosis of BPD and from supervision sessions and acknowledged that during these experiences the CPNs would accept and take on responsibility for the service user's distress (CPN1/Interview 1, Engaging BPD,/Service User Factors, reference 6). This was also associated with accepting responsibility for the service user's lack of progress and the construction of the CPN as being able to effectively work with all service users regardless of complexity. By being able to reflect upon the service user's responsibility within the therapeutic alliance together with their responsibility for maintaining the therapeutic contract, enabled the CPN's to reduce the intensity of anxiety and frustration previously experienced (CPN3, Interview 2; CPN Emotions; Reference 3).

Acknowledge limitations of Role

The shifting of responsibility to include the service user helped the CPNs to challenge pre-existing knowledge and beliefs associated with how they carry out the role of the CPN (CPN3; Interview 2; Interventions; Reference 3). In this context the CPN acknowledges the limitations in helping the service user stop harmful behaviours but instead focuses on a limited nursing intervention (Simpson 2005) in the form of crisis monitoring within the confines of the care co-ordination approach. Consideration of the complex nature of service user need, characterised by the role of other agencies involved in their care helped to focus the role of the CPN as care co-ordinator. Reflecting upon the importance of their role in bringing service user and agencies together to construct a holistic care plan helped to further

reduce the responsibility of the CPN in providing all the care that the service user required and helped them to acknowledge the important yet limitations of the role and the importance of a team effort in helping meet the needs of this group of service users. This acknowledgement of the role of the CPN further helps in the reduction of frustration and the refocusing of concern for the service user.

Supportive towards service user

The focus of the interventions is on providing support to the service user by involving them in care planning; developing crisis and contingency planning and restating the boundaries for the service user to follow. The monitoring of risks together with pragmatic problem solving strategies provides validation to the service user that they are still being offered a service whilst placing less pressure upon the service user to undertake care planning tasks which they find too demanding and difficult to complete (CPN1, Interview 2; Interventions, Reference 1). This provision of intervention is emotionally less demanding for the CPN and enables them to develop constructions of service user need based on their understanding and knowledge of the service user and the management of the disorder. This shift in emphasis to providing support is also an important step towards providing empathic responses for the service user to re-engage them back into the therapeutic alliance, an emotional experience which they may not always expect or are used to receiving from others.

Reduced Possibility of Confrontation

With the emotional climate of the relationship reduced and the focus on supporting the service user, the CPN is more collaborative in his or her approach and knows what to expect in their encounters with the service user (CPN1 /Interview1/ Workload/ Reference 5). There are no major surprises and they learn to react in predictable and emotionally less intense manner. This moves their reactions away from a personalised perspective to one which shares

responsibility and is less confrontational as a consequence (CPN1, Interview 1, Emotional Reactions to Service User, Reference 7).

Reduced Expectations for CPN Role

The construction of the CPN role as care co-ordinator has been questioned by Simpson (2005) as limited nursing where because of the paperwork involved reduces the opportunity for CPN's to engage with service users therapeutically. However perhaps an important function of the bureaucracy is to provide both the CPN and service user with a space in order to restate boundaries of their work to ensure that each understands the focus of the work and who is responsible for each component. In this way, the care coordination approach to case management promotes safety of the service user by maintaining their relationships with service providers (DH 2009). This may also provide an emotional respite from actual or potential ruptures within the therapeutic relationship and provide an opportunity to get back on track to regular appointments for the service user.

Slower Pace of Sessions

Due to the pervasive nature of the course of BPD and by its very definition that the service user's personality difficulties are stable in nature in that they are not likely to change quickly. Translating this into practice the CPNs reduced the frequency of their appointments and situating these in an environment which is more therapeutically neutral, for example a café (CPN1, Interview 1, Engaging BPD, Reference 7), results in the CPN and service user engaging on non specific factors which build the therapeutic relationship and trust. There is less emphasis on change but instead provides an opportunity for the service user to feel valued and to relate to others.

10.2 Implications for the CMHT

Research Aims

This study sought out to explore mental health nurses' actions, attitudes and beliefs about developing collaborative relationships with service users who have a diagnosis of BPD.

The aims of the research project were to :-

- Describe the beliefs of mental health nurses towards services users who have a diagnosis of BPD;
- Explicate taken-for-granted knowledge of mental health nurses towards services users who have a diagnosis of BPD; and.
- To alter practice by provoking critical reflection upon the findings with mental health nurses and practice supervisors

Desired outcomes associated with the research may relate to mental health nurses being more able to:-

- Reflect on their taken-for-granted knowledge of service users with a diagnosis of BPD.
- Explore socially constructed knowledge structures associated with the diagnosis of BPD.
- Improved therapeutic outcomes for service users with a diagnosis of BPD.

This study has important implications for how CMHTs and CPNs organise their work to meet the needs of service users with a diagnosis of BPD. Firstly from the wider CMHT perspective the CMHT may need to reflect upon it's current approaches to care delivery. This study has shown that in the case of BPD and others service users referred to a CMHT that the allocation of workers is made predominantly on either an individual case worker ie nurse, social worker , or together with the addition of medical staff to provide advice upon medication approaches. The focus of the team would appear to be that of a generalist nature with the emphasis upon allocation of resources ie allocating service users to staff. Given the

Department of Health's (2009a) current emphasis upon payment for results in that service users are clustered into specific groups dependant upon diagnosis and need which will lead to the development of a tariff on which provider mental health trusts' will be paid according to the service provided to that cluster group. Therefore the question arises of whether individual allocation of service users to single mental health workers will actually meet the comprehensive needs of service users and whether that will attract the lower tariff or whether CMHT's will need to evidence their specialist contributions to care delivery which will cost more and have an impact upon the capacity of the team to respond to current and future referral patterns. However this is in contrast to the Department of Health (2009b) guidance on Transforming Community Services which puts personalisation of needs and patient choice as the guiding vision for community services. However as mentioned elsewhere in this thesis access to such funds may be difficult for service users as accessibility criteria are used as a form of health and social care rationing.

In developing a specialist focus to care delivery, CMHT's will need to further integrate the taken for granted knowledge of the range of stakeholders that comprise the team and utilise this to enable them to identify their focus of intervention and key roles of team members within the plan of care. One method of achieving this is to utilise the framework of Evers (1981) to understand the relationship between team structure and it's effect on team behaviour. Using this model the observed team could move towards becoming a complex heterogeneous team which comprise a collection of specialist practitioners who are interdependent upon each other rather than what currently appears to be independent of each other. This contributes to potential conflict and game playing to get others involved or excluded from the care team. An example being the mentioning of medication or it's monitoring which would implicate medical and nursing staff respectively in the patient's care.

The development of the team would help to contribute an identity to the team which may further help in the assessment of service users and develop the stepped care model to accept service users into the service in which two or more members of the team would be involved and to clearly identify the roles and interventions. Being unable to identify these needs within service users at the assessment stage may be a more robust method of gate-keeping the boundaries of the CMHT and ensure that service user's access services based on the complexity of their need rather than having to fail at the previous step of intervention as is currently the case.

The development of the complex or specialist team to include this interdependency may also help to sustain supportive approaches within the team and reduce conflict. This may facilitate the embedding of team supervision approaches to further enhance team functioning and understanding of complex service user presentation and further support the team roles in use with the service user(s) thus improving team cohesion and mutual respect and support.

The development of team supervision initiatives would also help facilitate a change in the team's reflexivity. During the fieldwork phase of the study where the team referral and assessment meetings were observed, the judgements conveyed during case discussions would appear to relate to a knee jerk style of reflexivity. This according to Lynch (2000) is a habitual, thoughtless or instantaneous response. An example in the fieldwork was when one mental health worker provided an opinion of a service user who "sounded like trouble". Perhaps one function of supervision would be to enable the team to move away from this form of reflexivity to a methodological reflexivity (Lynch 2000) whereby the team observe and reflect upon their own reality and its relationship with the phenomenon of BPD. The team therefore examines it's relationship with the service user from a variety of standpoints, for example engagement; emotional reactions of service user and team members that enable the correction of biases and distortions. This approach may also reduce the impact of taken

for granted knowledge upon labelling and stigmatised beliefs towards the object, in this case the service user with BPD.

During the ethnographic interviews one participant reflecting upon the process of the interviews came to acknowledge the value of the approach as a form of supervision in the sense that a reflective space had been created for him to think about the challenges and successes of working with BPD. In this sense the researcher helped to emancipate the CPN from previous beliefs associated with why the service user was dropping out of therapeutic contact with the CPN. It may therefore be important that the provider of supervision is separate to the team so that the taken for granted assumptions and beliefs of the team are not confirmed by the supervisor and enable new constructions of BPD to occur at team level and thus facilitate alternative constructions which are not stigmatising in nature.

All CPNs in the study reported positive relationships in working with service users with a diagnosis of BPD and this was linked to focussing on service user problems and was generally within the early phases of contact. Conflict appeared to occur within the later stages of contact particularly when service user goals and CPN goals were in conflict for example when CPN 1 explored discharge the service user felt that he needed support for a longer period of time (CPN1/Interview1/ Therapeutic Withdrawal/ Reference 1); changes in the therapeutic contract between CPN and service user (CPN 2, Interview 1, Disengagement, Reference 2); or a relapse in self harming behaviours (CPN 3, interview 1, Engaging BPD, Reference 10). Interestingly the CPNs in different ways encountered the above engagement issues in the early, middle or later phases of the therapeutic relationship (Forchuk et al 1998) and it may be that these stages of engagement need to be clearly negotiated with service users during these transitions to maintain therapeutic contact with service users. This will now be explored.

The early stages of the therapeutic relationship is related to relationship building skills and during this study this was achieved by the CPN's by engaging the service user socially in non clinical environments (CPN 2, Interview 1, Engaging BPD, reference 3); clarifying roles and responsibilities (CPN3, Interview 1, Engaging BPD reference 11); being empathic and supportive (CPN1, Interview 1, Engaging BPD, reference 4), problem analysis (CPN 2, Interview 1, Engaging BPD., reference 2) whilst simultaneously managing service user risk (CPN 2, Interview 1, Engaging BPD, reference 9).

In a study of service user views of health services for service users with BPD, Webb and McMurran (2008) report that service user views of CPN's were generally mixed, in that from a positive perspective the CPN's were described as useful and provided a good service. From a negative perspective they were found to be judgemental, uninterested, obstructive and lacking in empathy. During this early phase of engagement it may therefore be helpful for the CPN's to develop an empathic understanding and more holistic view of the service user by exploring with service users their strengths and achievements; how they have solved problems in the past, their current needs and goals and their motivation to achieve these goals at present. By building this narrative account of their experiences the CPN and the service user will be able to build a positive identity of the service user rather than the stereotypical view which is permeated by the standard models in use by secondary care mental health services that service users with BPD are more difficult to manage (Newton-Howes et al 2008), are not treated with respect (Webb and McMurran 2008) with less therapeutic optimism (Markham 2003). It is contended that such positive constructions may enable the CPN to maintain therapeutic engagement with the service user when the therapeutic relationship is challenged by the re-emergence of service user need later in the therapeutic relationship.

A key finding of this study was the possible pathway for alienation when tensions occur within therapeutic engagement with the CPN's evaluating themselves as feeling either helpless or a failure which results in the activation of negative feelings. These feelings were then avoided by the CPN further evaluating the service users as "unlikeable" which reduced the CPN emotions but also reduced the CPN empathy for the service users. These evaluations may be reconstructed by the use of clinical supervision to enable the CPN to understand the relationship between the therapeutic relationship, resultant emotional reactions and the attribution framework used by the CPN to make sense of the current experience. McIntyre and Schwartz (1998) suggest that understanding of such reactions may lead to improved understanding of the service user. There was an example during data collection of this new understanding being developed by the CPN who initially attributed the non attendance as due to his cancelling a previous appointment and through the interview process a new construction was developed (CPN 2, Interview1, Understanding BPD, Reference 13). This related to the improvement of the service user enabling him to resume his previous relationship with his partner whose ending initially brought him into contact with the CMHT. The new construction enabled the CPN to understand some of the service user factors that may influence disengagement from services which he intended to follow up with the service user via letter contact. The provision of supervision in the CMHT is by a clinical psychologist who is not situated within the team but provides sessional input into the team for consultation and supervision.

This study has highlighted that individual practice is influenced by the team's discourse and the effect of this culture in maintaining stereotypical views towards BPD. The outsider perspective provided by the psychologist is also important in terms of providing an *etic* perspective on the team's discourse in working with a range of service users and may provide additional opportunities to construct the service users from outside the team

discourse as the psychologist has limited direct experience of the team culture. This may be an important factor in selecting the appropriate person to provide clinical supervision and it may not therefore be appropriate for this to be provided by clinical team members as they may perpetuate team discourse and thus further reinforce team practitioner views of service users.

From the literature it has been reported that service users with BPD are perceived to be harder to treat than other service users (Newton-Howes et al 2008), that it results in more counter transference feelings (McIntyre and Schwartz 1998) and possible alienation in mental health workers (Watts and Morgan 1994) leading to increased social distance in relationships (Markham 2003). This study has found the construction of the service user and also the construction of the professional role of the CPN to be important determinants of these views of BPD and resultant feelings.

Current constructions of BPD could be influenced by the provision of reflection on practice approaches and these should be provided to CPNs on a regular basis during the therapeutic contact with service users with complex needs such as BPD. This would enable the CPN to understand the therapeutic relationship and resultant emotions to facilitate new understandings related to both service users and the CPNs themselves. This approach would be similar to personal therapy that therapists' undergo to help develop self awareness and the effect on their own constructions on the therapeutic relationship.

An important aspect of the constructions in this study was the CPNs preference for working with specific categories of BPD (CPN1 Interview 2; Categories of BPD; Reference 7) and the frustrations that arose when mismatches with this preference occurs, for example when the service user is more difficult. This therefore raises two important questions, firstly should we match the preference of the CPN to their preferred service user? Or secondly, should we help the CPN to grow and develop by working with progressively more

challenging service users whilst supporting the CPN with additional training and access to supervision on a regular basis as explored above? Reflecting on the fieldwork component of this study and that only 3 of the 7 CPNs had BPD service users currently on their caseloads would suggest that the first scenario would appear to be in operation within CMHT's in that the other 4 CPNs had no preference for working with this service user group despite several service users with BPD being on the waiting list. In addition whilst there is supervision available it would appear that it is more an option than a pre requisite for working with difficult service users and that the approach is shared out among other workers thus the opportunity for receiving this on a regular basis may be difficult within such a scarce resource of one session a week of the psychologist. It would also appear that whilst there are a plethora of learning opportunities to enhance the skills of mental health workers working with BPD (Wright et al 2007; Duffin 2010) there would appear to be less emphasis for mental health workers including CPNs to participate within reflexive supervision whether on an individual or group basis to explore these constructions of BPD and self together with understanding the emotional reactions and attributions which flow from these constructions. In addition there would also appear to be less attention paid to the working practices and cultures to which students on such courses will return to and whether the dominant discourses within those cultures will permit less dominant models to flourish.

McCormack et al (1999) propose a tripartite conceptual model of practice development that involves the patient interface which includes clinical competence, and attitudinal change, the organisational interface which involves the combination of learning culture of the team and the clinical leadership of the team; and thirdly the strategic interface with the emphasis upon an enabling culture characterised by clear role definitions, shaped by local and national health policy. Since culture is produced and reproduced in their everyday acts (Bennis 1998), the authors conclude that all three components of the model must be

considered for successful practice development and for cultural changes to occur within teams. This is further supported by O' Neal and Manley (2007) who identify that sustainable cultural change is determined by interdisciplinary team work and communication; a culture of effectiveness and stakeholder involvement. Relating this to the CMHT would suggest that the current team need to develop reflexive structures to develop patient centred constructions of BPD; effective forums for multidisciplinary learning to occur; develop a vision for implementation of multiple models within the operation of the CMHT which would contribute towards meeting individual service user needs and further define the key roles, responsibilities and competencies required to meet the needs of service users with BPD.

In developing the culture of the CMHT would provide further opportunity for service development and skills development within the team. CPNs could develop expertise in working with BPD by having a blend of service user complexity on their caseloads at any given point in time so that they can further develop skills and expertise with the high functioning service users whom they feel confident in working with. In addition it would be important for the CPNs to develop expertise in service users that they are less confident with to facilitate growth in the areas of skills development and attitudinal adjustment. By framing this as a learning opportunity, a sort of internship in working with BPD may reduce the stake and interest of the CPN and may make this less personal and threatening for the CPNs to engage with the service users. An interesting finding of this study was that one CPN who was standing in for a colleague who was off sick, had less emotional investment with the service user and had less expectations for both his role and the therapeutic outcomes with the service user (CPN1 Interview 1/ Organisational Perspectives Reference 10). By doing less with the service user he was actually able to maintain therapeutic engagement and do more with the service user in containing his anxiety and possible self harming behaviours. Having less emotional investment may therefore be a protective factor for CPNs and this may be achieved

via clinical supervision, team discussions to identify the role and goals of interventions and those professionals within the team who will be providing these, and the development of learning contracts to enable the development of a reflexive practitioner together with the available support to enable growth and development of the CPNs.

An additional factor that influenced the CPNs to experience frustration was the (perceived) service expectations of increasing the throughput of service users across the CMHT and back into primary care. This implies that the CPNs would be unable to tolerate blocks to service user progress and underpinned their philosophy of achieving in a therapeutic sense desired outcomes with the service users that are referred and taken on for a service. One way of reducing this may be to offer such service users a time limited approach to interventions incorporating the recommendations of NICE (2009) that recommends that CMHTs provide a plan of care that incorporates short and long term goals and encompasses the management of crises. Such long term plans may include addressing housing needs; employment and social participation. Interventions should be psychologically informed and develop coping strategies to overcome service user deficits in this area. These interventions could be linked to the early, middle and later phases of therapeutic engagement with the middle phases emphasizing coping strategy enhancement; resilience building; strengthening self esteem; self soothing and nurturing approaches. The latter stages of therapy would relate to enhancing social participation and reducing stigma as well as developing advance directives and preparing for ending the therapeutic relationships. According to NICE guidance there is little evidence to support the use of psychological interventions with Borderline Personality Disorder and in this study the service users who have been exposed to attempts by the CPN to apply coping strategies to self harm has resulted in early termination from the engagement process (CPN2, Interview1, Emotional Reactions to Service User, Reference 7). It may therefore be important for the service user and CPN to develop their

understanding of the distress into a coherent account of the presentation and history linked to service user goals and expectations for therapy. Such work has been done in dementia care in the form of dementia mapping where the identity of the individual is recalled and includes the onset of dementia and is said to promote better adjustment by service users of the disorder (Kitwood and Bredin 1994). Perhaps that by building this narrative account of service users with BPD may strengthen the individuals' construction of self and their identity and help to reduce the negative effects of stigma upon their journey to recovery.

10.3 Implications for Delivering Recovery Focussed Interventions

The third aim in this study set out to improve the therapeutic outcomes for service users with a diagnosis of BPD. This will be explored with respect to the principles of recovery which is recommended by the chief nursing officer as the principal values base for mental health nurses regardless of setting (Department of Health 2006). The concept of recovery in mental health has been embraced by the National Institute for Mental Health in England (2005) to convey various meanings which imply a return to wellness; optimising functioning; empowerment and reduction of stigma together with achieving a personally acceptable quality of life. In a review of the British literature on recovery and utilising qualitative methods Bonney and Stickley (2008) identify 6 dominant themes from service users, healthcare providers and policy makers that describe recovery and these will now be utilised to explore the implications of this study for Community Psychiatric Nurses and the development of recovery approaches to care.

Identity: this relates to the construction of the service user to integrate the experiences of diagnosis into one's sense of self to further develop the self concept and involves accepting and understanding their experiences. Within this study the CPN's helped the service users to integrate their current experiences with past experience to help develop

further understanding and self concept which was linked to earlier experience of trauma (CPN2, Interview 1, Service User Needs Reference 2); past strengths in the areas of occupational functioning (CPN 3, Interview 1, Service User Needs Reference 1); and earlier relationships within the family (CPN 1, Interview1, Understanding BPD, Reference 9). A more eloquent example is provided by CPN 3 in integrating the service user's past relationships within the family and her current functioning whereby the self harm is an attempt to regulate feelings related to earlier comparisons with high achieving sister ((CPN3; Interview 2; Understanding BPD; Reference 1 and Reference 2).

The diagnosis of BPD appeared to be well understood by the CPN's in this study and the diagnosis did not exclude service users to access the CMHT service. Team discourse however was related to medical intervention, monitoring and risk management which defined the main interventions and roles of those involved in the care of the individual. However the CPN's recovery focus was related to facilitating discharge from services to become more independent and less demanding of the CMHT and goals were related to improving role and occupational functioning; participation in social activities and the provision of housing. The CPN's implemented pragmatic interventions related to overcoming deficiencies in the above areas of functioning together with limited nursing interventions related to risk assessment and management; crisis care planning and contingency management. It may be that by utilising a formal framework such as the recovery star (Triangle Consulting 2009) that this recovery focus can be better represented within the CMHT and enable the service user voice to be present in the CMHT care planning process and integrate the recovery model into the work of the CMHT which may better represent service user identity and needs, build upon existing strengths and be an important aid to care planning to maximise growth and potential.

Service Provision Agenda: This dimension relates to the provision of care where the current emphasis is upon outcome and evidence, and where the thrust of interventions have

been related to the eradication of symptoms which according to the literature may have significant meanings for service users. This approach therefore may be contrary to the recovery model in that these symptoms are part of the identity of the individual and support rather than cure may be required. This emphasis upon medication, monitoring risk and contingency planning was evident within this study and represents the biomedical approach which contributed to increased expectations within CPNs of eradicating symptoms which led to frustration and possible alienation of service users. By adopting recovery orientated approaches to the therapeutic relationship by providing support and understanding; the therapeutic use of self and acceptance approaches may be more advantageous to both service user and CPN in developing meaningful therapeutic relationships. This change in emphasis from short term interventions to longer term models of care may also provide additional opportunity for service users wary of developing trusting relationships to experience hope inspiring relationships.

The Social Domain: This relates to developing a social identity whereby service users are able to utilise mainstream facilities for leisure and vocational opportunities as well as accessing work and moving away from being labelled as mentally ill. Within this study the CPNs talked about their eventual aim of discharging service users from services and enabling them to reintegrate and within family and social networks (CPN1 /Interview 1/ Recovery Focus/ Reference 1): to enable the service user to go resume work activities (CPN3/Interview1/ Recovery Focus / Reference 3); and vocational activities (CPN2/ Interview1/ Recovery Focus/ Reference 1). Despite these recovery focussed interventions one CPN concluded that psychiatry and CMHT's were not very good at recovery models which was related to his understanding about restoring service user function to pre morbid levels (CPN1/Interview1/ Recovery Focus / Reference 4) rather than optimising to a quality of life that the service users were satisfied with which was evident in this CPN's interventions with

his service user which epitomised service user choice and pace of interventions (CPN1, Interview 1, Engaging BPD, Reference 12). Perhaps CPNs and CMHTs change of focus of interventions, for example by moving to a coaching model (Boyle 2004) with the focus of the approach is concerned with unlocking the individual's potential to maximise their potential for growth and development across a range of life areas. This would enable the CPN to move to a supportive, facilitating role and invite the service user to explore interventions according to their own needs, goals and aspirations. This approach may overcome some of the concerns that service users experience in accessing services and initiating a meaningful dialogue with care providers which is due to stigmatising beliefs of care professionals and also the limited availability of evidence based interventions (Nehls 1999) which appeared to provide justification for service users with BPD to be excluded from services. Coaching as an intervention may therefore be an approach which mental health nurses can use to overcome the competition and struggle for validation between service users and professional theories of intervention in BPD (Repper 2000) to enable collaborative approaches to social participation and other forms of intervention.

Power and Control: This dimension relates to service users feeling involved in decision making about their care and also that interventions are designed around their personal needs rather than feeling that they need to fit into existing services. Hegemonic struggles are found within the reviewed literature to include experts by experience rather than evidence based interventions which have resulted in professionals developing self management approaches not to empowering service users but to exclude as identified above. Within this study this dimension was located within the professionals who directed the care interventions and appeared to provide service user autonomy on a conditional basis and at the discretion of the professionals around the issues of responsibility (CPN 3, interview 1, Engaging BPD, Reference 3) and struggles for control could be a potential determinant of

alienation towards service users who did not always comply with the professional involved in their care (CPN1, Interview 2, CPN Emotional Attributions, Reference 10). Perhaps an alternative approach for enabling service user power and control would be for local authorities, CMHTs and CPNs to embrace the personalisation agenda (Department of Health 2010a) which would enable service users to have personal budgets for social care and they themselves would be able to determine the type of support required to meet their needs. However such funding is dependent upon service users fulfilling local authority eligibility criteria which are only likely to be available at the critical levels (Cestari et al 2006). Despite the policy rhetoric of increasing autonomy and control to service users the reality may be that personal budgets allocation will only be available to a minority of service users due to the financial pressures on local authorities to deliver social care with many councils raising the bar for service users to access such funding (Department of Health 2010b)

Hope and Optimism: This dimension is concerned with the set of beliefs from health professionals that recovery and optimising one's quality of life can be achieved and from this perspective the healthcare professionals can also enable service users to develop these healthy assumptions towards recovery. There are examples in this study of hope inspiring relationships between the CPN and the service users with BPD where the goals were related to normalising the service users presentation developing socially inclusive experiences within their local communities and networks (CPN3/Interview1/ Recovery Focus/ Reference 1); of enabling individual service users to reach their potential without reinforcing dependence (CPN1; Interview 2; Understanding BPD; Reference 3).

There was however a contradiction within the CPN's responses surrounding the recovery focus of the team with one view that nursing has always embraced a recovery focus and encapsulated the philosophy of the individual CPN to help people integrate into their communities and out of services (CPN3/Interview1/ Recovery Focus/ Reference 1). Another CPN held a

contradictory view that psychiatry is not very good at embracing the recovery model (CPN1/Interview1/ Recovery Focus / Reference 4) that the emphasis with BPD is on helping them adapt to their emerging crises whereas in psychosis after each acute episode there is a further deterioration in functioning compared to their previous remission which they never return to. Utilising a post modern critique on the history of psychiatric nursing, Chambers (2006) criticises the term “psychiatric nurse” as being likened to the handmaiden of psychiatry and informed by the biological model. According to McAllister and Moyle (2008) mental health nurses who do not have an explicitly defined model of intervention tend to revert to medical models of intervention due to it’s familiarity and dominance in healthcare provision. Given the historical and social contexts which influence the identity and subsequent practice models and interventions of community psychiatric nurses, it is of little surprise that perhaps the dominant discourse of the team which relates more to dependency and helplessness of service users with the inevitability in loss of functioning of the individual with prolonged course of the illness.

Professionally led models of service delivery according to Davidson (2005) lend responsibility to service users rather than share it and instead advocate a self management approach as a method to lending agency to individuals which is assumed to be a key ingredient in enabling the service user to embrace recovery (Lapsley et al 2002). Developing self management approaches by the employment of experts by experience within CMHT’s may therefore be a method of altering the dominant discourse of the teams and thus enable professionals to develop alternative constructions of BPD as colleagues and co-workers rather than as diagnostic entities.

However an important finding of this study was that the emotional reactions and attributions of the CPN’s contributed to the erosion of hope and optimism and invoked previous stereotypes which reduced therapeutic engagement. Long (1993) describes the process of healing in regard to coming to terms with a hysterectomy from emotional,

sociological and psychological perspectives. A key stage of the healing process was of letting go of painful memories, thoughts and images to enable alternative constructions of the service user as a woman to emerge. Developing this metaphor, mindfulness meditation approaches have successfully been used to help people recover or have more control over their physical pain related conditions (Kabat Zinn 1990) by helping individuals to notice their emotional reactions, judgements and attention focus to develop alternative constructions of self and their social world. Similar approaches have successfully been implemented with service users with recurrent depression (Teasdale et al 2000). The application of mindfulness meditation approaches may therefore be a useful intervention for staff themselves to experience which would help them develop their reflective capacity whilst working with service users with BPD and show themselves a less judgemental approach. This may be a more productive intervention to create hope inspiring relationships by enabling the letting go of stereotypical constructions and meeting individuals using a compassionate framework (Gilbert 2000).

Risk and Responsibility: this dimension views risk as a potential catalyst for change and there are examples of taking positive risks by the CPNs and this was related to giving more responsibility back to the service user (CPN 3, interview 1, Engaging BPD, Reference 5), about discharging the service user and managing risk within the relationship (CPN1, Interview 1, Engaging BPD, Reference 12), and of being available through disengagement by the service user and the risks associated with no involvement which can be challenging for the CPN (CPN 2, Interview 1, Disengagement, Reference 6). These examples highlight the tensions involved in attempting to keep the service user safe whilst at the same time promote autonomy (Bonney and Stickley 2008). Such tensions according to Pilgrim (2009) result from three differing ideological views about recovery, firstly a biomedical view where the emphasis is on medication and compliance and a paternalistic approach to treatment.

Secondly, discourse from social psychiatry where the focus is on social skills programmes to enable social integration. There is an analogy with rehabilitation approaches where recovery is associated with overcoming [social] impairments. Thirdly an emancipatory view is advocated with service users who demand freedom from coercive services. The author makes the interesting observation that the concept of recovery across the three main ideologies mainly pertain to service users who experience severe and enduring mental health problems such as schizophrenia and questions whether the meaning recovery can therefore be applied universally across diagnostic groupings such as those with common mental health problems or personality disorders. With regard to the latter group (Nehls 1999) reports that service users want access to services rather than to be divorced from services. This would therefore suggest an additional view of recovery which focuses upon humanistic principles where the emphasis is on developing healthy attachments and growth in human relationship to enable service users to further experience these conditions within their developing social networks. This would therefore suggest that CPNs would need to trade traditional frameworks which focus on risk and medicalisation and instead develop alternative frameworks which encompass collaborative relationships, service user narratives, helping service users to become aware of their taken for granted knowledge of how they respond in relationships and their emotional world. Such approaches would be facilitated by the CPN utilising a reflective lens on their therapeutic relationship and relationships which cause them concern. Such a lens would be created by empathic understanding; therapeutic relationship skills such as active listening, reflecting, paraphrasing and socratic questioning to help generate deeper understanding (Padesky 1993) and therapeutic alliance (Hovarth and Symonds 1990).

The findings from this study would also suggest that the sharing of responsibility not only promotes service user autonomy and choice but was also seen to be good for the CPNs' mental health in that they became less frustrated and anxious whilst working with this group

of service users ((CPN3, Interview 2; CPN Emotions; Reference 3) and helped to facilitate collaborative relationships. Therefore CPNs and CMHTs need to explore other more fundamental ways of meaningfully extending service user responsibility from not only areas of risk but to also include setting of appointments; focus of sessions; choice of CPN to match developmental needs in relationships, and to avoid mismatches in the sense of dependent service users being allocated to highly controlling mental health workers.

This study has identified two major findings associated with how CPNs interact with service users with a diagnosis of BPD. From an engagement perspective the maintenance of therapeutic relationships can be optimised when conditions are created within the therapeutic relationship for sharing responsibility between the CPN and the service user which can have a positive impact on service user collaboration and jointly manage tensions that may be evident in the therapeutic relationship. This approach which problem solves potential threats to the relationship may also create better emotional wellbeing for both service user and CPN which further optimises the therapeutic relationship.

Secondly the taken for granted knowledge and discourse of the CPN would appear to be a relevant factor in how therapeutic relationships and alliances can be maintained or deteriorate and these were related to attributions of likeability of the service user with deeper levels of meaning pertaining to the discourse and emotional reactions of the CPN. This is understood from an alternative perspective from the traditional writings of the psychodynamic therapist who would understand these reactions as examples of transference and counter transference which is firmly rooted within their relationship with the service user (McIntyre and Schwartz 1998). However, This study is not concerned with the psychodynamic frame of reference or concerned to explore the unconscious elements of interactions or to explain these interactions in terms of psychodynamic theories of attachment, defence mechanisms, or examples of unresolved conflicts (Murdin 2010) The

frame of reference for this study sought to explicate how BPD service users' identities were constructed by the interactions with the CPN's in the CMHT. This frame of reference is from a social constructionist perspective which contends that constructions of those identities occur as a result of the interactions between the service user, the CPN's and the culture that the CPN is part of ie the CMHT. According to Allen (2007) such language is localised and situated within the local culture and that the focus of the study is how language is used. It has been reported elsewhere within this study that the use of language in regard to the diagnosis of BPD is in itself socially constructed and is dependent upon the dominant discourses that shape mental health practice. For example the observed emotional reactions that occur between the service user and CPN are experienced but their explanations in terms of psychodynamic theory is one form of truth which has been contested by postmodern approaches as examples of oppression and marginalisation of women (Biever et al 1998). The social constructionist perspective in this study seeks to identify the range of discourses within the local culture of the CMHT that influence the construction of the identity of BPD by CPN's.

This study has identified clear implications of practice in terms of the recovery model that CPNs and mental health nursing is currently adopting. There is however a risk that those constructions of recovery will become universal and that a dominant ideology that relate to specific diagnostic entities such as enduring mental illness and the political stake and interest of various participants within that group will result in radicalisation of mental health service provision for other but disparate diagnostic groups. Service users with a diagnosis of BPD therefore have defined their recovery journey and articulated their needs from service providers that they actually need additional access to services which presents significant challenge to CMHTs whose dominant discourses relates to medical models; enduring mental illness and risk containment. CMHT's and CPN's therefore need to explore these tensions

and develop individualised approaches which spell out what recovery may look like for various service user stakeholders which may enable a truly individualised construction of the CMHT and CPN which meets the varied needs of very different service users who will need very different services at the same time.

11. Postscript

11.1 Implications for the term Borderline personality Disorder

The findings from this study have shown that BPD still remains a pejorative term when describing service user experience of this diagnosis. The literature shows that such a pejorative term is the result of the perceived untreatability and difficulties associated with managing this category of service user. In this study, the major discourses that I have found within the CMHT to explain service user experience related to the biomedical model and the language of psychiatric diagnoses. Such explanations however are historically and socially bound and psychiatric classification is used as a vehicle for access and exclusion to secondary mental health services. It was an interesting discovery to note that psychiatric knowledge and diagnosis is socially constructed and whilst community mental health nurses utilised the language of diagnosis in their assessment meetings and during their interviews they also constructed alternative categories to describe the service users they were engaging with. I have shown that these constructions relate to their degree of functioning, the problems that they presented with and also to do with factors related to the development and maintenance of the problems that service users experienced.

In this study I have demonstrated that the use of the diagnostic term BPD is both unhelpful and creates dissonance between the service user and mental health professionals even prior to initial and subsequent engagement. This study has shown that in this pre-meeting phase, constructions of BPD relate to previous difficult relationships with those service users and the potential emotional impact to the CPN of working with these categories of BPD. The term borderline is in itself a meaningless term (when applied to personality disorder) which neither describes the main features of the syndrome nor denotes what it symbolises. The category of borderline reveals a question about what it is that it is attempting to describe, in this way at face value it is an invalidating term which questions the very

essence of what it stands for. For example to denote something as borderline is to marginally include or exclude it from a larger category. Another construction of the term relates to the genuineness of the construct under investigation for example someone can be said to have a borderline level of intelligence which denotes the rank of an individual's intelligence within normative values of intelligence. Therefore the concept of intelligence is understood from a socially constructed perspective. With regard to BPD the border for service users relate to the border of psychosis or neurosis according to medical discourse; the border of vulnerability and coping according to psychological discourse and the border of being validated or ostracised within society according to feminist discourse (Bjorkland 2006). The historical context associated with the term borderline suggests that it is a form of exclusion and it would therefore seem important to question the validity of the term in favour with an approach to inclusion which optimises a recovery orientated approach.

A central aim of this study was related to my attempts to better understand the relationship between a recovery focussed approach and how this translated into therapeutic engagement with service users. As alluded to earlier I have found a tension between the dominant discourses of the team and adoption of recovery focused approaches. I think this is partly due to the historical journey that CPN's have travelled as subservient assistants to their medical masters, which have resulted in significant challenges for CPN's to develop their own professional identities. Understanding this from a socially constructed position has provided me with a better understanding of how social and work relationships operate within the CMHT and how power continues to be exercised by the psychiatrists and maintained by the other professionals. This has been demonstrated through both the observational and interview accounts of the CPN's.

11.2 Implications for practice

Previous studies exploring nurse's relationships with service users with BPD; personality disorders and good and bad patients have explained and described such accounts in terms of categorising the characteristics of for example difficult patients (Breeze and Repper 1998); Johnson's (1997) account of social judgement into relating to difficult patients in terms of labelling theory and the influence of power and control over those patients. Other theories describe difficulties in the relationship as examples of counter transference and account for labels that nurses give to service users such as being manipulative (Gallop 1988). What all these studies have in common is the linking of the nurses' emotional reactions to their difficulty in exercising power and control over service users and as such shine a narrow lens into the emotional and categorical world of the mental health nurse, in that the main object of focus is the service user. In this study I have taken an alternative approach and demonstrated the individual meanings that CPN's ascribe to themselves when faced with difficult relationships with the service users. In this study, unlike other previous studies, I have provided a model of understanding how malignant alienation can occur and have foregrounded the central role of CPN constructions and the various tensions that these represent in terms of their professional role; their role in the therapeutic relationships; their role as part of a multidisciplinary team and how their personal roles can collide with professional ones. I believe that I have demonstrated that it is fundamentally important to understand how these multiple discourses can influence from the mental health nurses' perspective therapeutic engagement with service users particularly when difficulties arise in the therapeutic relationship. It is anticipated that the identified pathway to alienation that were explicated from this study may be used by CPN's (and others experiencing tensions in their therapeutic relationships) in a reflexive manner as a possible roadmap which may be of some value utilising supervision and other reflexive approaches to help them develop alternative

constructions of the challenges presented by some service users with BPD and optimise therapeutic engagement when it is most needed by the service user and most feared by the CPN.

This roadmap can assist the CPN in explaining their emotional reactions to the service user and provide a vehicle to explore their various constructions of their professional self and use of situated language to uncover the attributions and evaluations of themselves and service users. Using as an example, the concept of responsibility for care goals and outcomes is an example of a concept that creates tension in the professional role of the CPN, with this having to be transferred to the service user to enable progress to be made with therapeutic engagement and recovery. Where this is facilitated it can result in increased engagement with the service user during potential crisis and act as a mediator of unhelpful emotions within CPNs.

Such meanings in this study were uncovered through the use of CPN's stories which contained a rich source of data which were taken for granted by the CPN's and the team as a whole. I have highlighted in this study how the exploration of such taken for granted knowledge can provide important insights into the CPN's knowledge structures. These may need to be identified and explored with CPN's by team leaders and clinical supervisors as an important focus for supervision to reduce possible malignancy in the therapeutic relationship.

11.3 Implication for Education and Training

In this study I have resisted approaches to understand the service user and community mental health nurses' experiences neither from any of these dominant discourses nor from the discourse of psychoanalysis; cognitive therapy or other psychological models of intervention. Instead I have favoured a social constructionist perspective which enabled the CPN's own constructions to emerge from the data collected within this study. The significance of this will now be explored.

The development of services and interventions are shaped by clinical knowledge and the effectiveness of these are further influenced in terms of patient outcomes and service delivery models. In the case of BPD the NICE guidance advocates the role of psychoanalytically informed therapeutic community treatment or dialectical behaviour therapy approaches. As a consequence such clinical knowledge and skills relating to psychological interventions is recommended within Department of Health Guidance that such skills should be adopted by generic community mental health teams. I believe that from both clinical practice and also on the results of this study such an approach is flawed for a variety of reasons. Firstly there will always be a place for such interventions to be provided by specialist practitioners in a specialist setting. Secondly as shown in this study, not all service users with BPD will benefit or be able to engage with such interventions within a generic CMHT; nor will all service users with BPD be able to engage with specialist providers. Fourthly it is erroneous to suggest or attempt to replicate such skills in a generic setting due to the shorter duration of training for non specialist practitioners and their limited experience of application of interventions with a clinical population that are of less acuity in their presentation compared to the typical service user acuity that are referred to the CMHT. Fifthly it is also very rare for such interventions to be replicated in non research based settings due to the degree of clinical expertise available in the research setting. Sixthly, practitioners from CMHT's who undertake specialist training in these therapies will find it difficult to implement these in practice due to a lack of clarity over roles and whether the leadership and culture of local teams will be innovative to support such practice development. Against the backdrop of these criticisms, I would therefore suggest that an alternative approach to skills development and engagement with service users with BPD is long overdue. The results of this study would suggest that the meanings and constructions that CPN's ascribe to themselves is crucial to the maintenance of empathy and the therapeutic

relationship with service users. Educational and supervision approaches need to be able to help the CPN understand from a critical perspective how these constructions have been shaped from personal, professional organisational and team perspectives and develop alternative reflexive approaches to construct therapeutic relationships. Such approaches would develop from reflexive methodologies rather than personal orientated approach to therapy as advocated by various schools of psychotherapy. Emphasis would be on self awareness, emotional maturity and intelligence and opportunities to engage in reflexive approaches to knowledge synthesis. In essence CPN's would develop expertise in models of relationship and personhood to facilitate engagement and manage potential ruptures within that relationship.

11.4 Methodological Implications

The methodology utilised in this study was informed by social constructionist approaches and can be viewed as a critical alternative to traditional psychology and social psychology approaches (Burr 2003). In this study I have shown that everyday interactions produce forms of knowledge that are taken for granted. Such taken for granted knowledge may be evident in stories and narratives that CPN's and CMHT's produce and therefore need to be explored to understand their attributional and evaluative frameworks together with the situated use of everyday language which may provide meaningful insights into the various stake and interests of the participants. Such approaches may be more beneficial than traditional forms of knowledge which become time and culture bound and cannot be taken as once and for all descriptions of human nature.

The use of social constructionist approaches provided a voice for both the CPN's and indirectly the service users with BPD. Within this study we have seen examples of CPN's accounts of service users' who have threatened the autonomy of the CPN and have been viewed as an adversary or enemy in this respect. According to Foucault (1991) this is an

example of a polemical practitioner who will never question their own propositions and categorisations and continues to position the service user as a threat (Roberts 2005). The study of these discourses has enabled me to better understand the historical resist the identify inherent within the and political discourses associated with the legitimisation of psychiatric knowledge within the CMHT and how this informs the individual practice of the individual CPN as a further example of the transformation into psychiatric subjects of service users who psychiatric diagnosis of BPD. It is therefore essential to utilise social constructionist paradigms to explicate such categorisations and to determine the impact of alternative constructions of BPD, to construct alternative identities of service users who threaten the power relationships with CPN's and to determine whether recovery approaches to understanding and interventions embed and alter dominant discourses of CPN's and CMHT's.

11.5 Limitations of Study

This study had several limitations. Firstly the results relate to one CMHT with a small sample size, within one very large NHS organisation and it may be difficult to universally apply the findings from this study to other CMHTs within this organisation and other NHS organisations. It would therefore be useful to replicate the study within other organisations and other CMHTs who work with people with BPD and explore their reactions to these service users. However given the widespread concerns in national policy for PD, the findings may be of interest to CMHTs in general.

This study only focussed upon the CPNs' experience of therapeutic engagement with service users with BPD as an attempt to understand their constructions of BPD as well as recovery focussed approaches. It would be useful to expand the participants to also include other professional groups to determine whether they had similar or alternative constructions

of engaging with BPD and to what extent their professional lens contributed or hindered therapeutic engagement.

Though this study only examined the CPNs' constructions of BPD it would be useful to also include service users' voices within the methodology to compare and contrast service user accounts with professional constructions and therefore provide a more realistic construction of the interactions of the relationship and how these were maintained or disrupted during the therapeutic engagement process.

Finally this longitudinal study focussed upon the first 6 months of engagement with service users who were taken on by the CMHT, it would be useful for further research to employ the ethnographic method to study both service user and CPN over an entire length of episode of care to better construct service user recovery and thus highlight the positive contributions that CMHTs and CPNs can contribute to this vulnerable and much maligned service user group.

Notwithstanding these limitations the study has demonstrated the value that can be added to service user recovery by the development of effective therapeutic engagement by the CMHT in general and CPNs in particular. Such engagement is seldom free from day to day challenges and these have been viewed from interpersonal, professional, team, ethical, and political perspectives. The CPNs within this study have been able to articulate their constructions of BPD and their professional selves to enable their emancipation from their taken for granted knowledge, practice and routines to help build better identities for themselves and their service users with BPD.

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13. Appendix 1: Participant Information Leaflet and Consent Form

Northumberland, Tyne and Wear 
NHS Trust

Participant Information Sheet

Study Title: Engaging service users with a diagnosis of Borderline Personality Disorder: an Ethnographic Study.

REF No:

Part 1.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

- *Part 1 tells you the purpose of this study and what will happen to you if you take part.*
- *Part 2 gives you more detailed information about the conduct of the study.*

What is the purpose of the study?

This research study will help facilitate understanding into the complex nature of mental health nurses attitudes, assumptions and beliefs that both facilitate and prevent therapeutic engagement and recovery orientated approaches with service users who have a diagnosis of Borderline Personality Disorder. The results of the study may help to develop educational and supervision approaches to improve recovery with this group of service users. In addition it may also be of use in developing practice by provoking critical reflection on the findings with mental health nurses.

Why have I been chosen?

The participants are mental health nurses working in community mental health team settings in the Northumberland Tyne and Wear NHS Trust.

Do I have to take part?

No, the decision to take part is completely voluntary. Please read this information sheet and if you do decide to take part, sign the attached consent form and return in the addressed envelope. You will be given a copy of the signed consent form. You will be free to withdraw from the study at any time. If you decide to withdraw from the study any data collected will not be used in the study.

What will happen to me if I take part?

You will be invited to participate in in-depth conversations reflecting on the therapeutic relationship that you have with a service user with a diagnosis of Borderline Personality Disorder. The conversation will be no longer than 60 minutes duration and it will be audiotape and transcribed later. This will be subject to your consent and transcripts will be shared with you for accuracy. You will not be identified in the transcripts and anonymity will be maintained by not including your name or the participating team in any records/ reports generated from the study.

It is anticipated that you will meet with the lead researcher on a regular basis three occasions during developing therapeutic engagement with service users with a diagnosis of Borderline Personality Disorder. These meetings will occur at the beginning of the therapeutic process and at 3months and six months into the engagement process.

Expenses and payments:

Any expenses that are incurred as a consequence of participating in the research project, for example travelling expenses can be reclaimed through the trust's expenses reimbursement procedures.

What do I have to do?**The participants' responsibilities:**

- Consent to participate in research project
- Obtain approval from line manager to participate in study.
- Arrange appointments with researcher
- Arrive for in depth conversation in good time.
- Inform researcher in good time if unable to keep arranged appointment.
- Reflect with researcher on therapeutic engagement with a service user with a diagnosis of Borderline Personality Disorder.
- Inform the lead researcher if they wish to withdraw from the research study.

What are the other possible disadvantages and risks of taking part?

There are minimal risks in taking part in the study. These may relate to thoughts and feelings about service users that are reflected upon but are not likely to be harmful.

The participant may experience some inconvenience in taking part in the study as it involves frequent in depth conversations, which may take careful planning to arrange. It is not likely to be harmful. Any discomfort that the participant experiences should be explored by the participant via their supervision and other pastoral support procedures that are available to them.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get might help improve the therapeutic engagement of people with borderline personality disorder. This may include improved educational approaches; reflection on practice; supervision approaches and skills development

What happens when the research study stops?

All data will be collated and then stored in a secure place. This will be in accordance with the trust's policy on Retention and storage of records, which relates to the Department of Health Guidelines (HSC 1999/053).

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The details are included in Part 2.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2. Any complaints relating to the study should be communicated to:-

Mr Gary O'Hare
Director of Nursing
Northumberland Tyne and Wear NHS Trust
St Nicholas Hospital
Postcode
Telephone: 01912130151 ext 32830

Contact Details for Lead Researcher:

Angus Forsyth
Nurse Consultant
Adult Acute In-patient Services
Northumberland Tyne and Wear NHS Trust
Hadrian Clinic
Newcastle General Hospital
Westgate Road
Newcastle upon Tyne
0191 2130151 ext 23069

Mobile 07884183412

e-mail: Angus.Forsyth@nmht.nhs.uk

Part 2

Complaints:

If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions (07884183412). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from Northumberland Tyne and Wear NHS Trust.

Harm:

In the event that something does go wrong and you are harmed during the research study there are no special compensation arrangements. If you are harmed and this is due to someone's negligence then you may have grounds for a legal action for compensation against (Northumberland Tyne and Wear NHS Trust) but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

Universities and other public bodies employing researchers have vicarious liability for their actions, and are expected to insure against risk of claims against the University and its staff relating to clinical trials they design and undertake in their University employment. They may have clinical trials insurance that covers both negligence and no-fault compensation; this would normally exclude clinical negligence for which NHS bodies are liable. Appropriate statements should be included in the IS as required by the approving REC.

Will my taking part in this study be kept confidential?

All information, which is collected, about you during the course of the research will be kept strictly confidential. If applicable: Any information about you, which leaves the hospital, will have your name and address removed so that you cannot be recognised from it. All procedures for handling, processing, storage and destruction of collected data are compliant with the Data Protection Act 1998. Specific precautions to maintain confidentiality and anonymity include:-

- Data will be collected by audio taping of in depth conversations on a regular basis.

- All data will be transcribed and stored securely. Participants will be given a code, which will only be identifiable, by the lead researcher.
- Once data is transcribed all tapes will be wiped clean by the lead researcher.
- Data in the transcribed data will not contain identifying information and anonymity will be maintained.
- Data will be used for this study only.
- The lead researcher, academic supervisor and assessors will have access to view aspects of the identifiable data.
- Data may also be scrutinised by the trust's R&D audit for monitoring of the quality of the research study.
- Data will be stored in accordance with the trust's policy on Retention and storage of records, which relates to the Department of Health Guidelines (HSC 1999/053).
- Participants have the right to check the accuracy of data held about them and correct any errors.

What will happen to the results of the research study?

Research finding will be disseminated via peer-reviewed journals such as the Journal of Psychiatric and Mental Health Nursing; professional conference presentations; and local professional and user forums.

Who is organising and funding the research?

The research project is part of my dissertation for the Doctorate in Nursing Science, which I am undertaking at University of Northumberland. I am being supported by my organisation Northumberland Tyne and Wear NHS Trust to undertake the research and funded by the Non Medical Education and Training Levy administered by Newcastle Primary Care Trust

Who has reviewed the study?

This study was given a favourable ethical opinion for conduct in the NHS (or private sector) by :-

- University of Northumbria Ethics Panel
- Newcastle and North Tyneside Local Research Ethics Committee

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION SHEET.

Study Number:

Participant Identification Number for this study:

CONSENT FORM

Title of Project: Engaging service users with a diagnosis of Borderline Personality Disorder: an Ethnographic Study.

Name of Researcher: Angus Forsyth

Please initial box

1. I confirm that I have read and understand the information sheet

dated (version) for the above study. ☐

2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time, ☐

Without giving any reason, or my employment rights being affected: ☐

4. I understand that relevant sections of any data collected during the study, may be looked at by responsible individuals from University of Northumbria ☐

from regulatory authorities or from Northumberland Tyne and Wear NHS Trust, where it is relevant to my taking part in this research. ☐

5. I agree to take part in the above study. ☐

Name of Participant

Signature

Date

_____	_____	
Name of Person taking consent (if different from researcher)	Date	Signature

_____	_____	
Researcher	Date	Signature

When completed, 1 for patient; 1 for researcher site file; 1 (original) to be kept in medical notes

12. Appendix 2. Conference Presentation Abstract

Explorations in Ethnography, Language and Communication: Perspectives on Data

Thursday 23rd & Friday 24th September 2010, Aston University, UK

IDENTITY (Room 552), 14.00 – 15.30

Constructions of 'Borderline Personality Disorder' in Clients referred to a Community Mental Health Team: An Ethnographic Study

Angus Forsyth and Michael Hill (Northumbria University)

Despite the modernisation agenda of the National Health Service in general, and mental health services in particular, the specific needs of service users with a diagnosis of Borderline Personality Disorder continue to be neglected by various service providers including community mental health teams (CMHT's) (National Institute for Mental Health in England (NIMHE) 2003)

Care settings provide the social context in which mental health nurses both organise the delivery of care (Sun *et al.* 2005), but also, more subtly, construct meanings concerning diagnosis and the prospect for 'effective intervention'. An ethnographic design was employed in order to develop an understanding of the social norms operating within one Community Mental Health Team (CMHT). It is argued that such norms are critical in delineating professionals' meanings, orientations, and subsequent social actions towards 'referrals' as well as determining the extent to which clients are able to access services.

Ethnographic investigation presupposes that knowledge, interaction and social actions are inseparably linked together and become bound in situated social norms that serve to frame what permissible in terms of actions towards and treatment of other people within the same social setting (Hammersley & Atkinson 1983). According to Potter & Wetherell (1987) the operation of taken-for-granted knowledge can be revealed by focussing upon (a) dilemmas of stake and interest in interaction, and (b) the methods and means by which blame and accountability are constructed and managed in social actions (including retrospective accounts of these actions).

This presentation will focus on the observation phase of the study which involved observing the CMHT referral and assessment meetings on a weekly basis for 8 weeks. The social meanings and corresponding actions related to accepting or rejecting of clients referred to the Community Mental Health Team are explored. Related to these actions are discursive processes by which various discourses are afforded 'factual' status, and hence become objectified and legitimised as part of the clinical assessment. Dilemmas of stake or interest both within the team and between the team and the referred client (and how these serve to frame the actions and outcomes of the meeting) are discussed.

